EVALUATION OF THE BUSOGA AND EAST ANKOLE DIOCESE COMMUNITY FAMILY PLANNING PROJECTS

POPTECH Report No. 96-075-043
October 1996

by

Eliot T. Putnam
Susan E. Adamchak
Florence Oryem-Ebanyat
Edward C. Green
Suellen Miller
Oscar F. Picazo
Elizabeth S. Ralston

Prepared for

U.S. Agency for International Development
Bureau for Global Programs
Office of Population
Contract No. CCP-3024-Q-00-3012
Project No. 936-3024

Edited and Produced by

Population Technical Assistance Project
1611 North Kent Street, Suite 508
Arlington, VA 22209 USA
Phone: 703/247-8630
Fax: 703/247-8640
E-mail: poptech@bhm.com

The observations, conclusions, and recommendations set forth in this document are those of the authors alone and do not represent the views or opinions of POPTECH, BHM International, The Futures Group International, or the staffs of these organizations.

TABLE OF CONTENTS

ACKNOWLEDGMENTS v
ABBREVIATIONS vii
EXECUTIVE SUMMARY ix
LIST OF RECOMMENDATIONS xi

1. INTRODUCTION 1

1.1 Family Life Education Project 1
1.2 East Ankole Diocese Family Planning Services Project 1
1.3 Delivery of Improved Services for Health Project 2

2. METHODOLOGY AND FOCUS OF THE EVALUATION 5

2.1 Quality 6
2.2 Integration 6
2.3 Replicability 6
2.4 Impact 7
2.5 Sustainability 7

3. REPRODUCTIVE HEALTH SERVICES 9

3.1 Introduction 9
3.2 Methodologies 9
3.3 Family Life Education Project 10

3.3.1 Service Quality 10
3.3.2 FLEP Training 10
3.3.3 Training Capacity 11
3.3.4 Supervision/Quality Assurance 11
3.3.5 Integration of Reproductive Health Services 12
3.3.6 Summary 14

3.4 East Ankole Diocese Project 14

3.4.1 Service Quality and Integration 14
3.4.2 Supervision and Training 15
3.4.3 Medical Student Component of EAD 16
3.4.4 Summary 17

3.5 Recommendations 17

3.5.1 Recommendations for FLEP 17
3.5.2 Recommendations for EAD 17
3.5.3 Recommendations for Both Projects 18

4. COMMUNITY OUTREACH: FLEP AND THE USE OF VHWS 19

4.1 Introduction 19
4.2 Role of the VHW 19
4.3 Supervision 20
4.4 Motivation and Compensation 20
4.5 Other Concerns 21
4.6 Social Marketing 21
4.7 Impact of VHWs on Family Planning and Child Survival 23
4.8 Sustainability of VHWs 23

4.8.1 Financial Sustainability 23
4.8.2 The Importance of Community Participation 24

4.9 Applying the VHW Experience to DISH 25
4.10 Recommendations 25

5. COMMUNITY OUTREACH: THE EAD EXPERIENCE 27

5.1 Introduction 27
5.2 Function and Problems of CBDs 27
5.3 Conclusions 28
5.4 Recommendation 28

6. INFORMATION, EDUCATION, AND COMMUNICATION 29

6.1 Introduction 29
6.2 Development of FLEP's IEC Strategy 29
6.3 Face-to-Face Health Education 29
6.4 Print Materials 30
6.5 Quarterly Newsletter 31
6.6 Radio and Audio Cassettes 31
6.7 IEC in Schools 32
6.8 Integration of Family Planning and AIDS/STI Messages 32
6.9 Strengths, Weaknesses, and Impact of IEC 32
6.10 Recommendations 33

7. DEMOGRAPHIC ISSUES 35

7.1 Introduction 35
7.2 Project Performance 35

7.2.1 FLEP 35
7.2.2 EAD 37

7.3 Contraceptive Prevalence: FLEP 39
7.4 Contraceptive Prevalence: EAD 41
7.5 Contraceptive Method Mix 42
7.6 Couple Years of Protection 42
7.7 Fertility Impact 44
7.8 Recommendations 45

8. HEALTH INFORMATION SYSTEMS 47

8.1 Status of Project Systems 47
8.2 Data Use 48
8.3 Target Setting 48
8.4 Qualitative Data Collection 50
8.5 Recommendations 50

9. ORGANIZATIONAL DEVELOPMENT AND MANAGEMENT 51

9.1 FLEP: Structuring for Sustainability 51

9.1.1 Strategic Plan 51
9.1.2 Organizational Status 51
9.1.3 Management Issues 52
9.1.4 FLEP-Government Interface 53

9.2 EAD and FLEP: Overall Management Issues 54
9.3 Recommendations 55

10. FLEP FINANCIAL SUSTAINABILITY 57

10.1 Introduction 57
10.2 Cost Recovery Programs 57

10.2.1 Cost Recovery from Contraceptive Services 57

10.2.2 Cost Recovery from Curative Services/Drugs 58
10.2.3 STI Drug Revolving Fund 59

10.3 Assessment of Cost Recovery Efforts 59
10.4 Services Amenable to Greater Cost Recovery 60
10.5 Public Sector Support 61

10.5.1 Current Inputs 61
10.5.2 Potential for Expanded Collaboration 61

10.6 Other Avenues to Sustainability 62

10.6.1 External Sources 62
10.6.2 Endowment Fund 62
10.6.3 Corporate/Private Sponsorship 63
10.6.4 The Church 63

10.7 Conclusion 63
10.8 Recommendations 64

APPENDICES

A. Scope of Work
B. Bibliography
C. List of Contacts
D. Quality of Care Assessment Method
E. FLEP and EAD Quality of Care Indicators Score

ACKNOWLEDGMENTS

In conducting this evaluation, the evaluation team received support and assistance from many quarters. The USAID Mission in Kampala welcomed us warmly and was unfailingly attentive in its technical and logistical support. Pathfinder offices in Nairobi and Kampala, through generosity with their time and responsiveness to our questions, gave clear evidence of the organization's total commitment to its mission in Uganda. In addition, the POPTECH office, especially Sylvia Megret, was characteristically helpful throughout the assignment.

The team will remember with particular pleasure and nostalgia the time it spent in the field with the staffs and workers of the Busoga and East Ankole Diocese projects. From project managers to community health workers, from nurses' aides to senior nurse-midwives, they demonstrated enthusiasm, creativity, and a deeply held commitment to the well-being of the mothers, children, and families of Uganda. We learned from them and were inspired by them.

Finally, we thank two people who gave unstintingly of their time and counsel throughout our month in Uganda. In so doing they contributed greatly to our understanding of the role these projects have played in Ugandan health care. Joy Mukaire of Pathfinder showed through her energy and intelligence why she has been such a positive force in FLEP's rise to pre-eminence among Ugandan NGOs (official or otherwise) and, more recently, in coordinating community-based distribution activities of the entire DISH Project. Cecily Banura of USAID brought tremendous insight and good humor to her multiple roles as host, mentor, and advisor to the team, and in so doing contributed substantively to the quality of our work.

Eliot T. Putnam, Jr.
Susan E. Adamchak
Florence Oryem-Ebanyat
Edward C. Green
Suellen Miller
Oscar F. Picazo
Elizabeth S. Ralston

August 15, 1996

ABBREVIATIONS

AIC	AIDS Information Centre
AIDS	acquired immunodeficiency syndrome
AMREF	African Medical Research Foundation
CA	Cooperative Agreement
CBD	community-based distributor/distribution
COPE	Client Oriented Provider Efficient Assessments
CPR	contraceptive prevalence rate
CRHW	community reproductive health worker
CSM	contraceptive social marketing
CYP	couple year of protection
DHS	Demographic and Health Survey
DISH	Delivery of Improved Services for Health Project
DMO	district medical officer
EAD	East Ankole Diocese Project
FLEP	Family Life Education Project
FP	family planning
FPAU	Family Planning Association of Uganda
HIV	human immunodeficiency virus
HLD	high level disinfection
IEC	information, education, and communication
IPC	interpersonal communication
IUD	intrauterine device
MCH	maternal and child health
MIS	management information system
MOH	Ministry of Health
MSRDP	Multi-sectoral Rural Development Program
NGO	nongovernmental organization
OC	oral contraceptive
OR	operations research
ORT	oral rehydration therapy
PAC	postabortion care
QOC	quality of care
REDSO	Regional Economic Development Services Office
RHS	reproductive health services
SDP	service delivery point
SOMARC	Social Marketing for Change Project
SOW	Scope of Work
STI	sexually transmitted infection
TA	technical assistance

TASO	The AIDS Support Organization
TL	tubal ligation
TOT	training of trainers
UDHS	Uganda Demographic and Health Survey
U.S.	United States
USAID	United States Agency for International Development
UShs	Ugandan shillings
VHW	village health worker
VSC	voluntary surgical contraception
WRA	women of reproductive age
YMCA	Young Men?s Christian Association

EXECUTIVE SUMMARY

At the request of USAID/Uganda, a seven-person team of consultants spent three weeks in Uganda in June 1996, conducting evaluations of two church-based community family planning (FP) projects: the Family Life Education Project of Busoga Diocese (FLEP) and the East Ankole Diocese Family Planning Services Project (EAD). Supported with USAID/Washington funds by Pathfinder International (FLEP since 1986 and EAD since 1990), the projects offer important lessons in the effective delivery of integrated reproductive health services at the community level.

Strengths and weaknesses of these projects have particular relevance for the Delivery of Improved Services for Health Project (DISH). Recently funded through a Cooperative Agreement between USAID/Uganda and Pathfinder, DISH is a long-term effort to expand work begun under FLEP and DISH to 10 of Uganda's 39 districts. The goal is substantial expansion of FP, improvement of maternal health, and major reductions in the incidence of HIV, AIDS, and other sexually transmitted infections (STIs).

The evaluation team was asked to assess project performance and make recommendations in the context of five variables: quality, integration, replicability, impact, and sustainability. It found services offered under FLEP to be of excellent **quality**, thanks to high training and service standards, well-developed supervisory systems, opportunistic information, education, and communication (IEC), and the energy of a unique cadre of volunteer village health workers (VHWs). The team urges the reinstatement of recently terminated VHW travel allowances to ensure the maintenance of this important community service model. The team found EAD services to be of acceptable quality, but it urges their full integration into the DISH system to enhance impact in an underserved region.

The **integration** of FP and other reproductive health services has been improving in both projects but is not yet complete. Health personnel tend to emphasize FP over STI/AIDS counseling, maternal and child health (MCH), and other services. The team strongly suggests this imbalance be rectified through refresher training and supervision that emphasize the importance of integrated messages. It also suggests approaches to improving the integration of private and public sector services in both project areas.

The long-term importance of FLEP and EAD will be measured by the extent of their **replicability**, especially under DISH—hence, the team's recommendation that the uniquely successful FLEP VHW model be maintained long enough for testing against and comparison with others—in Uganda and elsewhere in Africa. Not all approaches are transferable, but one that is at once so productive and economical deserves to be given every opportunity. FLEP has also developed training and technical assistance capabilities that are already being used by DISH and should be exploited further, ideally on an income-generating basis.

While, anecdotally speaking, it is clear that FLEP and EAD have had substantial **impact** of various sorts, more precise research and analysis are needed to quantify these conclusions. Although crude estimates seem to indicate an impressive contraceptive prevalence rate (CPR) of over 18 percent in the FLEP project area, an internal Pathfinder survey of demographic impact was too flawed to be definitive, and the team recommends that a new survey be undertaken. Catchment areas of EAD and FLEP also need to be more carefully mapped to better gauge impact and plan coverage. In another sphere, a careful assessment of impact and cost effectiveness of radio and other IEC approaches, using focus groups and/or operations research (OR), could be instrumental in determining future IEC priorities, especially for DISH.

Finally, the team considered issues of **sustainability** of project innovations, especially with respect to FLEP, in an era of diminishing external resources. At this point, the various cost recovery approaches that are in effect, even with optimum performance, can generate only a small percentage of needed operating expenses. The team made a number of recommendations for potential new sources of local support to be explored, starting with the development of a FLEP endowment fund. All options will require time and careful study, and meanwhile it is hoped that some external resources will remain available to sustain a uniquely worthwhile project.

The team also made a number of management-related recommendations. It urges that the process of obtaining official designation of FLEP as a Ugandan nongovernmental organization (NGO) be accelerated, setting the end of 1996 as the target for final approval. It suggests the need for clarification of Pathfinder/Uganda's oversight responsibility for FLEP and EAD as full elements of DISH notwithstanding the origin of their funds. In addition, it urges the FLEP Board of Trustees to move quickly in resolving internal management issues that are detracting from urgent operational needs.

These and numerous other recommendations are detailed in the following pages. In presenting them, the evaluation team is well aware that, in their totality, they present FLEP as a project worthy of continuation of its somewhat "special status" as a proving ground and technical resource for primary health care in Uganda, while suggesting that EAD, as a somewhat less mature and dynamic project, will be best served by becoming an integral part of DISH. In no way is the latter suggested in a pejorative sense, only with a desire to do what is best for EAD.

Both FLEP and EAD are initiatives of which Pathfinder, USAID, and, most particularly, FLEP and EAD managers and staff can be immensely proud. The evaluation team felt privileged to be allowed to learn about and offer suggestions to projects of such substance. They deserve, and we wish them, a flourishing future.

LIST OF RECOMMENDATIONS

1. FLEP provider salaries have not been paid on time (or at all) recently, resulting in demoralization and some resignations. Every effort should be made to rectify this situation in the interest of maintaining morale and ensuring good performance. (p. 17)

2. Family planning is still the main focus in many FLEP health units, with messages on STI/HIV, for example, often an afterthought. Training, in the form of on-the-job role playing sessions with supervisors and short courses on integration, should reinforce the importance of integrated messages and services. (p. 17)

3. Zonal managers, with fewer days for supervising FLEP providers, must manage their time more efficiently. For example, the number of supervisory visits to high performing providers can be reduced. The latter might also function as resource persons to back up zonal managers. (p. 17)

4. EAD should relocate FP/antenatal services at Ruharo within the health unit next door in order to provide a wider range of services, ensure privacy for client counseling and examinations, and improve integration of RHS. (p. 17)

5. A medically trained supervisor (physician or nurse) should be added to the EAD team to complement the skills of the project manager and provide monitoring and training for providers. (p. 17)

6. EAD service providers should be included in all DISH training, especially the Comprehensive RHS Training Program, as an important step in bringing EAD more fully under the DISH umbrella. (p. 17)

7. In light of the concerns expressed as to the quality and impact of the medical student component of EAD, funding for transportation and travel stipends for students and their supervisors should be immediately discontinued. (p. 18)

8. Operations research is recommended (resources permitting) to monitor client loads and devise strategies for continued improvement in management of integrated services and clients with multiple health problems. (p. 18)

9. Integration of messages on FP and STI/HIV prevention should be strengthened through further training and support supervision. (p. 18)

10. Individual FP counseling sessions observed were excessively long. Providers should be re-trained in effective and <u>efficient</u> counseling skills. (p. 18)

11. Newer clinical concepts, such as concurrent use of barrier contraceptive methods with non-barrier methods (e.g., IUDs) for STI prevention or use of OCs for emergency contraception, should be introduced into training curricula and service protocols, preceded by appropriate baseline research. Postabortion care should be fully instituted as part of integrated RHS. (p. 18)

12. Negotiating skills for condom use and STI prevention should be role played during counseling. IEC activities should stress and model male involvement and contraceptive practice. (p. 18)

13. A quality assurance evaluation by a local consultant (but one external to the project) should be conducted six months to one year after the above recommendations have been implemented to determine their effectiveness. (p. 18)

14. The travel allowance for VHWs should be reinstated, at a level to be determined by Pathfinder and FLEP, for at least two years. The issue should be reassessed at that time in light of (1) findings of a survey on VHW impact on FP, AIDS/STI, and child survival; and (2) results of OR to determine the relative cost-effectiveness of the full-time, compensated VHW versus the part-time, uncompensated CRHW of DISH. Such research could be expanded to examine the question of VHW compensation in other African countries, using USAID/Washington OR resources. (p. 25)

15. After review of DHS and other studies and discussion with the MOH and DMOs, FLEP should adopt key indicators of impact on child survival that can be easily monitored along with existing family planning targets. Impact in broader areas of MCH will help justify reinstatement of a transportation allowance for VHWs. (p. 26)

16. FLEP and EAD should maintain and, if possible, expand their social marketing activities in rural areas. To date the social marketing activities are modest in design and impact, however, they provide access to services for underserved populations and can serve as a base for more vigorous CSM initiatives in the future. (p. 26)

17. In keeping with other, more specific recommendations, integrate EAD fully, in both the administrative and programmatic sense, into the larger DISH Project, enabling it to benefit fully from DISH training and other resources. (p. 28)

18. Operations research should be conducted to assess the impact and cost-effectiveness of FLEP's face-to-face, entertainment-oriented approach to IEC in various settings, including schools, in terms of changes in knowledge, attitudes, and contraceptive usage for family planning and disease prevention. (p. 33)

19. If funds can be found, FLEP radio broadcasts should be reinstated and a listener survey conducted to determine comprehension, message recall, and evidence of behavior change. (p. 33)

20. Focus groups should be convened, if possible for little or no cost, to assess the quality of and receptivity to FLEP's own informational leaflets. (p. 34)

21. If the suggested assessments so warrant, size of IEC teams should be scaled back to free up FLEP personnel to serve as IEC trainers for the DISH Project. Senior VHW IEC team members with in-service training skills might also be hired by local NGOs and international health organizations to conduct IEC training. (p. 34)

22. A concerted effort should be made to identify specific elements of IEC (training, performances, sale of cassettes) that could generate income for FLEP's IEC activities, if not its broader program. Technical assistance in this area should identify which components and activities to develop and how to market specific services and materials. (p. 34)

23. A new FLEP survey should be undertaken, along lines suggested in the text, to more accurately assess program impact in project areas in terms of primary health care, STI treatment, child survival, as well as family planning. (p. 45)

24. Catchment areas of both FLEP and EAD should be reviewed and, where necessary, more clearly defined in order to provide a map from which more reliable measures of coverage and impact can be estimated. (p. 45)

25. Both projects should develop simple, easy-to-use user manuals with instructions on how to input data, perform calculations, and generate reports from their data systems. These should include step-by-step instructions for accessing files and templates and examples of the tables and graphs produced. (p. 50)

26. Greater effort should be made to tailor targets to the individual service delivery areas based on criteria such as catchment area population size, current CPR, or proximity to alternative sources of services. Targets should be regularly reviewed and revised as necessary to conform to changing realities in the particular areas to which they apply. (p. 50)

27. The process of obtaining official NGO status for FLEP should be energized, with Pathfinder exercising whatever leverage it can with the FLEP Board of Trustees, toward the goal of FLEP becoming a legally approved Ugandan NGO before the end of 1996. (p. 55)

28. The FLEP Board of Trustees should move quickly to fill the positions of FLEP project manager (the evaluation team feels that the acting manager is a very acceptable candidate) and program analyst (combined with resource development if an acceptable candidate can be found). (p. 55)

29. The Board of Trustees should obtain the technical assistance necessary to review in detail, finalize, and promulgate a strategic plan for the organization which combines realistic program plans with resource development strategies. (p. 55)

30. Increased attention should be paid to enhancing synergy between FLEP/EAD and DMOs and other public sector health entities. Ideas suggested in the text could provide a point of departure. (p. 56)

31. It should be made clear that full responsibility for technical and management oversight of FLEP and EAD rests with Pathfinder/Kampala. Pathfinder/Nairobi should play an advisory role as it does with its other projects. (p. 56)

32. All viable opportunities for cost savings and cost recovery should be explored by FLEP management, including opportunities to benefit from MOH/DMO resources through closer collaborative relationships. (p. 64)

33. As prospects for continued external support diminish, particular emphasis should be given, with technical assistance provided as needed, to developing the idea of a FLEP endowment fund and generating corporate and other private Ugandan support for FLEP activities. (p. 64)

1. INTRODUCTION

Two church-based family planning (FP) projects, funded by Pathfinder International under its central USAID/Washington Cooperative Agreement (CA), have served as important laboratories for testing approaches to community-based delivery of FP and other services in selected areas of Uganda over the past several years. The lessons to be learned from an evaluation of their respective experiences are critical to the success of a third, much larger community-based distribution (CBD) program recently initiated under a USAID/Uganda CA, with Pathfinder the principle implementing agency.

1.1 Family Life Education Project

The Family Life Education Project (FLEP) of Busoga Diocese of the Anglican Church of Uganda was established in 1986 as part of the Diocese's Multi-sectoral Rural Development Program (MSRDP). FLEP represented the first involvement in Uganda for Pathfinder International, whose continued support, using both USAID and private funds, has helped the project evolve over the past 10 years into a major community outreach program. It offers FP counseling and services, sexually transmitted infection (STI) diagnosis and treatment, HIV/AIDS counseling and referral, maternity care, and other preventive and curative services in three districts of Eastern Uganda: Jinja, Iganga, and Kamuli.

With a project-trained staff of over 70 technical, supervisory, and service personnel, FLEP serves a population of over 500,000 through a network of 48 church health centers, built and managed by the communities in which they are located. A major and, for Uganda, highly innovative element of the project is its use of a cadre of 170 trained village health workers (VHWs) as the primary community contact points for FP/STI/AIDS education and counseling, contraceptive sales, and clinic referral.

FLEP's growth has been substantial, and in 1994 a decision was made to seek registration as an independent Ugandan nongovernmental organization (NGO). Confirmation of NGO status is awaiting official Government approval, which FLEP hopes to obtain before the end of 1996 (see Chapter 9 on organizational development). Nevertheless, FLEP has clearly established a significant reputation in the FP community, both in Uganda and elsewhere in Africa.

1.2 East Ankole Diocese Family Planning Services Project

The East Ankole Diocese Project (EAD) was initiated in 1990, again with Pathfinder support using USAID central funds. Smaller and less well known than FLEP, EAD sought to expand access to FP services through clinic-based and mobile outreach services in two underserved

districts of Western Uganda, first Mbarara and later Ntungamo. Using a variation of the FLEP model, the project recruited and trained community workers to serve as community-based distributors (CBDs), providing FP information and selling pills and condoms to their communities. They also refer clients for other services to one of 10 fixed sites, usually on church premises, which are visited on a monthly basis by project mobile service teams working out of the FP clinic at diocesan headquarters at Ruharo (also project supported).

Additional community outreach is provided by fourth-year medical students from Mbarara University as part of their curriculum in community medicine. This year, 43 students are conducting reasonably regular visits to communities in the project area to provide residents with information on FP and other primary health care issues, sell non-prescription contraceptives, and refer clients to project health centers for services.

Because they have been supported with USAID/Washington funds and were initiated well before Pathfinder established an office in Uganda, both FLEP and EAD have historically been managed and supervised out of the Pathfinder regional office in Nairobi. Only recently have they been incorporated into a new, much larger CBD project in Uganda, which is funded by the USAID Mission and managed out of the recently opened Pathfinder office in Kampala.

1.3 Delivery of Improved Services for Health Project

In part due to the significant latent demand for FP services demonstrated by these projects, USAID/Uganda launched the Delivery of Improved Services for Health Project (DISH) in 1994. Pathfinder, in collaboration with a number of subcontractors, is implementing the community reproductive health component of DISH under a Cooperative Agreement signed with USAID/Uganda in May 1995.

Under this component, Pathfinder is making a series of sub-grants to local NGOs to implement integrated reproductive health service projects in six districts previously lacking such activities, using FLEP staff for training, monitoring, and supervision. In addition, although still supported by Pathfinder's USAID/Washington funds, USAID/Uganda and Pathfinder/Uganda consider FLEP and EAD to constitute the DISH community reproductive health component in Jinja, Kamuli, Mbarara, and Ntungamo. Thus there are 10 "DISH districts" overall.

DISH is designed to provide integrated reproductive health services in its target districts and the training and technical inputs needed to upgrade government personnel skills and facilities. At its core is the development of community-based contraceptive distribution systems and referral networks for FP, maternal and child health (MCH) care, STI diagnosis and treatment, and HIV/AIDS testing and counseling. Community awareness-raising and mobilization is again the responsibility of a specially trained cadre of CBD agents, now referred to as community reproductive health workers (CRHWs).

Clearly, FLEP and EAD have unique significance for DISH. While components of the larger project, they also predate it. FLEP has 10 years of experience from which to draw and EAD six. Furthermore, FLEP staff members are used for training, monitoring, and supervision of DISH project personnel. As DISH gathers steam, with activities now beginning or underway in most of the new target districts, an analysis of FLEP and EAD successes, failures, and lessons learned can make a substantial contribution to DISH?s growth and maturation.

2. METHODOLOGY AND FOCUS OF THE EVALUATION

Under the terms of a Scope of Work (SOW) drafted by USAID/Uganda, a six-member team of health and FP professionals spent three weeks in Uganda, beginning June 11, 1996, and conducted a detailed evaluation of the FLEP and EAD projects. The team included a senior official of the Uganda Ministry of Health and five consultants from the United States. A seventh team member, representing the USAID/REDSO office in Nairobi, participated in the exercise for approximately 10 days. Before arriving in Kampala, the expatriate members of the evaluation team spent one working day in Nairobi for briefings at the Africa Regional Office of Pathfinder International.

Following three days of briefings, discussions, and document review in Kampala, the evaluation team spent 10 days in an extensive series of visits to project sites in Jinja, Iganga, and Kamuli districts (for FLEP) and Mbarara and Ntungamo districts (for EAD). The purpose was to meet and gather impressions from as many people as possible involved with or affected by the projects, past or present, in public and private sectors, and in as random and un-preprogrammed a manner as possible. In all cases the team was greatly assisted by FLEP and EAD project managers and their staffs, who gave willingly of their time to discuss all aspects of their projects, arrange itineraries, and make requested contacts.

The team met with district medical officers (DMOs) and other health officials to gather their assessments of the role that the projects had played in the context of the newly decentralized national health system. It spoke with the Bishops of Busoga and East Ankole Dioceses about the church's role in furthering primary health care in general and FP in particular in Uganda. It interviewed FLEP Board of Trustees members, university officials and students, sessional doctors providing project clinical services, and DISH trainers and other staff in the regions.

Using questionnaires and topic guides designed by team members, the team conducted extensive interviews with providers, VHWs and CBDs, supervisors, trainers and, perhaps most importantly, clients to assess the quality of services offered within project facilities. In the process it visited close to 30 project service points and other facilities, many in remote rural locations. Observations under the subject headings that follow derive from these visits and interviews. In most cases, because FLEP and EAD are different in so many respects, observations are offered separately for each project, although conclusions are combined where appropriate.

Finally, the team's findings, conclusions, and recommendations are structured so as to respond to questions posed in connection with five key variables articulated in the evaluation SOW: quality, integration, replicability, impact, and sustainability.

2.1 Quality

The evaluation team concerned itself with assessing quality in all aspects of FLEP and EAD, particularly in connection with services, both clinical and informational. With specially designed questionnaires, role plays, and other tools, the team made a searching analysis not only of clinical services but also of the extent to which project personnel monitored quality indicators and took steps to rectify weaknesses. Assessments were made of such things as technical knowledge in FP and STI/AIDS diagnosis and treatment; FP method mix in project facilities; communication and counseling skills; and the quality and availability of information, education, and communication (IEC) materials.

The quality of primary and refresher training of VHWs/CBDs and clinic personnel was also assessed, with emphasis on demonstrated proficiency of trainers in FP, STI diagnosis and treatment, and AIDS education and counseling. The team looked at supervisory skills present in the projects, the frequency of monitoring visits, and the abilities of supervisors to effect qualitative change based on their observations.

2.2 Integration

A key indicator of long-term viability of project models tested under FLEP and EAD is the extent to which counseling and services are presented as an integrated whole. The evaluation team closely examined the extent to which providers understood the concept and importance of integration and efficiently and effectively linked the provision of FP, maternal health, STI, and HIV services. It assessed the obstacles to integration that have been encountered and suggested solutions, both in training and in the design of appropriate "packages" of services that should be offered at different levels.

The team also looked at private and public sector integration. It was mindful that FLEP and EAD have functioned within the church rather than as a part of public sector health structures and that the DISH Project has been designed ultimately to strengthen public sector services. Thus the impact of the projects will have been enhanced in direct proportion to their success in sharing project ideas and innovations with DMOs and their staffs and maximizing coordination, joint planning, and the sharing of resources and facilities.

2.3 Replicability

Lessons learned from the projects are intended to be applied to the DISH Project as it matures. Therefore, the evaluation team was continually preoccupied with the need to identify those elements of FLEP and EAD that are most readily transferable and those that should be discarded, or at least not repeated. For example, it looked at the draft agreements with other NGO

participants in DISH (such as the YWCA and the Islamic Medical Association of Uganda) to see what aspects of FLEP's experience as a nascent health NGO would be most instructive and which were too expensive or otherwise unrealistic to replicate.

Again with reference to FLEP, the team made a detailed evaluation of its capacity as a provider of training and other technical assistance outside of Busoga Diocese, with an eye to recommending that these services might be made available to newer projects and institutions on a fee basis.

2.4 Impact

Through a review of existing reports and studies, along with on-site analysis of service statistics, the team attempted to verify published contraceptive prevalence rates (CPRs), especially in FLEP project areas. It assessed the quality of the research that generated the data and suggested additional research needed to accurately quantify the projects' demographic and health impact.

The team also looked at the goals and targets set within the projects, their appropriateness, quality, and the extent to which they either hindered or helped the assessment of impact. It assessed the management information systems (MISs) used to collect and analyze project data. More subjectively, it also assessed the impact on public sector health services of the institutionalization of extensive networks of church-based, i.e., private sector, health service facilities.

2.5 Sustainability

No single issue preoccupied the evaluation team (or indeed preoccupies most individuals and institutions concerned with economic and social development) more than what Bishop Bamwoze, the principle creator of FLEP, referred to as "this animal called sustainability." Especially in light of their role as laboratories for the new CBD projects being implemented under DISH, the team continually sought to identify those elements of FLEP and EAD that could be copied and used with minimal, or at least diminishing, financial obligations from outside donors.

With particular reference to FLEP, the team looked in depth at its prospects for increased financial independence from outside sources, particularly once its NGO status is assured. It looked at ways to reduce costs, offer training and technical services to public and private sectors on a fee basis, achieve program efficiencies through better coordination with the DMO, and establish an endowment fund. In the process it sought to help all concerned come to grips with current funding realities and with the need to begin far-reaching, hardheaded financial planning of a sort not previously contemplated.

It should be mentioned that the evaluation team's assessment of prospects and possible avenues for long-term project sustainability was not solely influenced by the reality of inexorable reductions in funding for foreign assistance, at least from U.S. sources. It also sought to temper this awareness with a counterbalancing truth: when trying to jumpstart or maintain ambitious programs in a challenging environment, an excessive preoccupation with sustainability can often be a deterrent to essential early progress. With undertakings as large and complex as FLEP, EAD, and DISH, it is critical that one not preemptively shortchange the up-front investments needed to get things started and/or carry momentum forward. Otherwise, the projects may not develop to a point that makes them worth sustaining.

3. REPRODUCTIVE HEALTH SERVICES

3.1 Introduction

The evaluation team was asked to assess the quality and the degree of integration of reproductive health services (RHS), including MCH, FP, STI diagnosis and treatment, and HIV/AIDS education and counseling, in the FLEP and EAD projects by answering questions such as:

- Are services offered under the two projects of acceptable quality, and where is there room for improvement? Do project personnel properly monitor quality issues?

- Is providers' and VHWs' technical knowledge of FP, STI diagnosis and treatment, and HIV/AIDS as it should be? Are communication and counseling skills adequate in these areas? Are all services integrated? What problems have been encountered in the process? What is the most reasonable package of integrated services for VHWs and clinic staffs to provide in each project?

- Is the FP method mix appropriate? Is the provision of STI, HIV/AIDS, and MCH services balanced as compared to FP? Are appropriate materials on services and methods available and properly used?

- Are trainers qualified to upgrade the skills of service providers and VHWs in MCH, FP, STI diagnosis and treatment, and HIV/AIDS education and counseling?

- Are trainers effective as supervisors? Is observation of actual service delivery a part of supervision? If so, what types of observations are made? How systematic are these observations and how are they synthesized and used?

3.2 Methodologies

To answer these questions, the team used a variety of methodologies, detailed in Appendix D. They included survey questionnaires, checklists, role plays, observations, and structured interviews. Due to time constraints on the number of contacts possible, the team used qualitative rather than quantitative measures to present its findings.

In both project areas the team observed numerous client/provider interactions, including immunizations, antenatal and postnatal consultations, labor and delivery, FP counseling and services, STI/HIV counseling, and various provider and VHW IEC activities. It held post-interaction interviews with clients; interviewed service providers, VHWs and CBDs, zonal managers and VHW supervisors, university students, and sessional doctors; and conducted

facility/equipment assessments.

3.3 Family Life Education Project

3.3.1 Service Quality

Service providers (enrolled midwives and nurses, registered nurse-midwives, public health nurses, registered nurses, and medical assistants) are selected by health committees of communities where health facilities are located. Their basic Ministry of Health (MOH) training is augmented by FLEP to enable them to provide integrated RHS. Existing skills are reinforced and newly acquired skills maintained through updates and refreshers. A key element in maintaining service quality is the work of supervisors/trainers, known as zonal managers (see below), who combine training and quality assurance in their supervisory duties.

FLEP management and staff, community leaders, and Pathfinder should be congratulated on developing, training, and sustaining an excellent team of providers offering high-quality services. The project is a model of community participation and development, effective use of external technical assistance to develop internal capacity, ongoing supervision for quality assurance, a client-centered service approach, and the beginnings of truly integrated RHS. In most cases the evaluation team felt that women's lives are valued by FLEP providers, especially as demonstrated by their attention to the health and social burdens imposed on women by unplanned pregnancies.

3.3.2 FLEP Training

Service quality cannot be maintained without a strong knowledge base and frequent updates and refreshers. In the FLEP Quality of Care Indicators Score (Appendix E) items 14 and 15 refer to the adequacy of training received by zonal managers, service providers, and VHWs. The evaluation team assessed training by reviewing the basic education of providers at time of hire; looking at the specialized FLEP/MOH/African Medical Research Foundation (AMREF)/AVSC training curricula used to bring providers up to desired levels; noting availability and adequacy of training materials; and reviewing Uganda MOH policy guidelines for FP/MCH service provision. In all cases the team found training to be of a very high standard.

FLEP training inputs included the following:

- Refresher training in basic contraceptive technology for all providers in l992, l993, and l994
- Intrauterine device (IUD) insertion training for 39 providers (others are receiving on-the-job training from zonal managers)
- AIDS counseling training for 60 providers, 1993 and 1994

? MIS training workshop for all providers
? Refresher training in diagnosis and treatment of STIs for all providers, l995

Training gaps were perceived in more advanced areas, such as the use of barrier contraceptive methods for STI prevention by women using non-barrier methods (usually IUD), use of oral contraceptives (OCs) as emergency contraceptives, and postabortion care (PAC). The latter, referred to as PAC/FP in Uganda MOH terminology, is not perceived as an unusually serious problem in FLEP or EAD regions but is considered an important element of comprehensive RHS. Because of the high incidence of STI/HIV, all women clients whose HIV serostatus and that of their partners is unknown or discordant couples or HIV-positive concordant couples should be encouraged to use barrier methods.

Adding these elements to training regimens will require sensitivity and careful planning and may need to be preceded by appropriate baseline research. For example, more precise knowledge of STI incidence in women using IUDs with and without barrier protection would be important to the quality of both training and services.

3.3.3 Training Capacity

FLEP staff members were initially trained by the MOH MCH/FP Master Training Team and external consultants. When training demands outpaced the capacity of the MOH, FLEP developed its own core training team, consisting of specialists in management, clinical skills, community development, and IEC. However, even with its own team in place, FLEP management was unable to keep up with provider training needs.

To address this imbalance the role of FLEP's clinical supervisors was expanded by sending them to training of trainers (TOT) courses. Renamed zonal managers, they now assist the core training team in identifying training needs and in planning and conducting training courses (initial or refresher) for providers, VHWs, and community leaders. Most importantly, they provide on-the-job training (such as in IUD insertion) to providers they supervise.

All eight FLEP zonal managers were originally service providers themselves and as such are qualified to act as providers whenever required. This has been important of late, since 15 clinical staff members left FLEP in the last two quarters due to non-payment of salaries and better prospects in the public sector.

3.3.4 Supervision/Quality Assurance

Supervision and quality assurance occurs during monthly supervisory visits by zonal managers to each service delivery point. Using a series of checklists as tools, managers ensure that quality

objectives and goals are being fulfilled and uniform delivery standards upheld. Each provider has copies of these checklists, is aware of proper procedures, and knows she/he will be observed at length during supervisory visits, which always include direct observations of client interactions, not just records reviews.

Providers are visited monthly, with weaker performers receiving more frequent visits. On occasion a supervisor may "role play" a procedure for the provider or model a technique with a client. The provider participates in self-critique and developing plans for improvement. Comments are written in the provider's Supervisor's Book, checklists filed in the FLEP office, and providers monitored to see if weak areas are strengthened. In one instance, a provider's attitude toward FP clients was perceived as insensitive. Despite extensive attempts at remediation, her performance did not improve and she was let go.

Finally, service providers, administrative staff, and communities participate in Client Oriented Provider Efficient (COPE) Assessments (looking at clinic wait time, client satisfaction, etc.), which result in action plans for clinic quality improvement.

Under the DISH Project, FLEP zonal managers are slated to spend seven to eight days per month, on alternating months, training DISH CRHWs in other districts. Concerns have been expressed as to the impact this will have on ongoing FLEP supervision/training requirements, and attention must be paid to balancing needs. One way to more efficiently allocate zonal managers' time may be to reduce the number of supervisory visits to high performing service providers.

3.3.5 Integration of Reproductive Health Services

In its first two phases, FLEP concentrated on creating demand for and providing quality FP services. In the third phase, with the endorsement of community and religious leaders, the diagnosis and management of STIs and HIV/AIDS and related counseling, along with basic MCH services, were integrated into the training of providers and VHWs and the services they offered. In the process numerous advantages were perceived, problems encountered, and lessons learned.

Coverage. Most FLEP clinics now provide some combination of FP, basic curative services, identification and management of STIs/HIV, and MCH services. The latter include antenatal/maternity/postnatal care, immunizations, growth monitoring, and/or treatment of diarrheal diseases and respiratory tract infections. As shown in Table 1, total integration of RHS is in effect in 25 percent of the 48 FLEP sites and present in varying degrees in the remainder.

Clearly, FP and curative care predominate, with the mix of other services influenced by various factors. In one clinic, STI/HIV, maternity care, and curative care were provided on a daily basis and antenatal care and immunization on one day each. One explanation for the limited care was that

staff persons were doing community outreach and could not attend to all clients on some days. Another was that immunizations, which require refrigeration, were only available through the cold chain one day per week.

The provision of STI/HIV services in particular has been increasing since their introduction in l994. In the first quarter of l995, STI identification/referral accounted for eight percent of service activities. In the first quarter of 1996 it accounted for 19 percent. Over the same period there was a 42 percent increase in numbers of clients seen for STI services. Clearly, integrating RHS at FLEP service points has had a positive impact on the willingness of community residents to seek a range of primary care services from their health units.

Table 1

Integration of RHS at FLEP Service Delivery Points

Services Offered	# SDPs (%)	
FP, Curative Care, Management/Identification of STIs	48	(100%)
FP, Curative Care, Management/Identification of STIs and Immunization and Growth Monitoring	34	(70%)
FP, Curative Care, Management/Identification of STIs, Immunization and Growth Monitoring, and Total Maternity Care (antenatal and delivery)	12	(25%)
FP, Curative Care, Management/Identification of STIs, and Antenatal Care	12	(25%)
FP, Curative Care, Management/Identification of STIs, Antenatal Care, and Immunization and Growth Monitoring	6	(12.5%)

Source: FLEP service records.

Other advantages have been perceived as well. Previously clients were embarrassed to be seen, for example, as specifically seeking STI care. Now that providers are trained and equipped to address multiple issues, client confidentiality is protected. Time saved is another important factor. For example, mothers bringing children for immunization can also receive information on FP, counseling on STIs, or curative care.

Problems encountered. While communities benefit from access to a broader range of RHS, the pressure on staffs due to these new responsibilities is apparent. Most FLEP health posts employ

only one trained nurse/midwife and one nursing aide, with three to four VHWs covering the catchment area. It is a challenge for such a team to deliver the full range of services. VHWs note the inherent conflict between the size of their areas of operation and the need to now spend more time counseling individual clients. Clearer guidelines on the extent of integrated counseling and services to be provided by VHWs are needed. One place to start could be in the length of time devoted to individual FP counseling sessions. The evaluators noted a tendency of FLEP providers to be overly detailed and long-winded in their presentation of contraceptive options.

At the clinic level, not all providers are trained in syndromic management of STIs nor do they have the necessary drugs for STI treatment. Although most referrals are appropriately made, the evaluation team learned of numerous instances where women were delayed in obtaining referral services due to long distances, lack of money for transport, or objections from husbands or relatives.

Monitoring. Zonal managers remind providers that "reproductive health problems are different, and every client should be considered for all types of services." Providers first are trained in principles and concepts of integration, which are then reinforced during supervisory visits. Monthly reports require VHWs to indicate whether service was delivered in an integrated manner, and supervisors' checklists allow for feedback about successes and problems in integrating services. Providers record the number of clients by services provided, and STI drug use is also monitored.

3.3.6 Summary

Appendix E rates quality of services in FLEP health units. With a few exceptions, FLEP providers and VHWs were rated highly by the evaluation team. They were well trained, alert, and responsive to clients' needs. Especially commendable, given the rural settings and lack of storage and work space in some of the smaller health units, was the adherence to strict infection control procedures, including high level disinfection (HLD). Even the smallest unit had a supply of "Jik" bleach, soaking containers, water sources, and heat sources for boiling or autoclaving instruments.

Some instances of stock-outs of necessary equipment were observed, as were units that did not allow for adequate patient privacy or where there were noticeable gaps in staff skills. But all in all the picture was one of high-quality services steadily becoming more effectively integrated.

3.4 East Ankole Diocese Project

3.4.1 Service Quality and Integration

Service providers observed and interviewed at the central EAD clinic at Ruharo and one of the

project's mobile outreach clinic sites demonstrated excellent interpersonal communication (IPC) skills, technical knowledge, appropriate infection prevention techniques, and effective IEC approaches. They provided high-quality care despite cramped quarters, especially in the Ruharo office where confidentiality and privacy were hard to achieve. All FP methods were available and demonstrated during counseling, although only Depo-Provera and OCs were supplied or resupplied during the team's observations.

On the down side, not all patients were informed as to which FP methods do not protect against STIs, and no clients left with condoms in addition to their Depo-Provera/OCs. Infection prevention methods, although meticulously carried out, were often hampered by inadequate work space and limited staff members. While FP services at Ruharo were excellent, they were not integrated with the full-service diocesan clinic located just next door. At another fixed site (Kinoni) integrated RHS were available, including a maternity suite and recovery/postnatal ward, but these facilities looked little used and dirty.

The mobile clinic sites generally provided FP, ante- and postnatal care, and some STI management, with referrals for maternity care. Family planning services appeared to be made available to married couples only, although single adults may purchase barrier contraceptives. Postabortion services were not apparently available.

Interviews with CBD agents or "CBDs" (the EAD equivalent of VHWs) from different catchment areas in the project region indicated that their level of competence depended on the amount of training received and length of service with the project. Longer-term CBDs, mostly in Mbarara district, were clearly knowledgeable in referring to STI/HIV/AIDS during their interactions. Those in Ntungamo district, which was added to EAD relatively recently, were more tentative. They were still getting used to promoting FP and were not yet fully conversant with all aspects of integration.

Of all FP methods provided during the most recent quarter in EAD, 89 percent were voluntary surgical contraception (VSC) or Depo-Provera. All methods were available at most fixed or mobile clinic sites, and referrals could be made to Mbarara Hospital for VSC or NORPLANT?. However, clinicians noted that when clients were referred for the latter, as elective patients they were often "bounced" in favor of emergency surgical cases. Very often these patients could not afford another trip to Mbarara, and thus never received their preferred method. (A planned new VSC clinic at Ruharo will, however, improve access for women seeking longer-term methods.)

3.4.2 Supervision and Training

Since the EAD project manager is an Anglican pastor and does not have clinical training, project providers are without medically trained supervision. While this makes their excellent performance doubly impressive, it means that there is no one readily available to monitor their work in the technical sense and with whom they can consult. A sessional doctor comes to the Ruharo clinic

weekly, but he is generally too busy to assist providers. One provider attended a quality of care (QOC) workshop in l995, but others have had no training of any type since l993. The lack of refresher training and the absence of supervision is disturbing, especially in light of the planned opening of the VSC unit at Ruharo. Surgical services require the presence of strong medical oversight.

It should be said that the EAD CBD supervisor was, at the time of the evaluation, attending the DISH Project Comprehensive RHS Training Workshop outside Mbarara. Her attendance represented a first for incorporating East Ankole personnel into DISH training, and, it is hoped, was only a beginning step in bringing EAD within the DISH orbit in terms of both training and technical assistance.

3.4.3 Medical Student Component of EAD

A unique feature of EAD has been its use of medical students from Mbarara University to supplement the work of mobile teams and CBDs in bringing FP and other primary health care information and counseling to communities in the project area. The medical students interviewed by the evaluation team were, in most cases, positive about their experiences in the EAD Project. For example, one said that giving IEC talks and making house-to-house visits was an important contribution to his goal of becoming a community health practitioner interested in RHS.

Other students noted, however, that this aspect of their program of study had lower priority than others, as it was not the main focus of their career paths. This was reflected in a lack of in-depth understanding of their informational/counseling roles. For example, in response to a question on the handling of FP rumors and problems with side effects, students' answers tended toward blanket reassurances rather than individualized care plans.

Exit interviews with clients were informative in this regard. Of eight clients interviewed at the Kinoni health center (one of the base sites for student outreach), all had unanswered questions about side effects of FP methods they were using or considered using. Most felt that the medical students they had seen were not responsive to their questions about side effects. None of the clients were aware of their risks for STIs and their knowledge of FP methods was incomplete. Some of the symptoms the clients described to the interviewer (a physician) sounded like they needed medical management, not the casual reassurances given by the medical students. Despite IEC activities by the CBDs and medical students in their villages, these clients were still very concerned about negative FP rumors.

Due to the spotty impact of this component, the team urges discontinuation of travel allowances for students and their supervisors. While this will reduce the size of this cadre of workers, those who continue on their own or with University support will show strong commitment to this service, a net gain for EAD.

3.4.4 Summary

Appendix E summarizes quality indicators for integrated clinic- and community-based reproductive health services in EAD. Ratings cover providers, CBDs, and medical students.

The relatively weak scores (in comparison with FLEP) reflect an overall lower quality of services provided under EAD than under FLEP. However, the evaluation team believes that, with proper supervision and upgraded facilities and training, the project's skilled and motivated providers will be able to raise these scores. Reevaluation for quality of services should be performed after remediation.

3.5 Recommendations

3.5.1 Recommendations for FLEP

1. FLEP provider salaries have not been paid on time (or at all) recently, resulting in demoralization and some resignations. Every effort should be made to rectify this situation in the interest of maintaining morale and ensuring good performance.

2. Family planning is still the main focus in many FLEP health units, with messages on STI/HIV, for example, often an afterthought. Training, in the form of on-the-job role playing sessions with supervisors and short courses on integration, should reinforce the importance of integrated messages and services.

3. Zonal managers, with fewer days for supervising FLEP providers, must manage their time more efficiently. For example, the number of supervisory visits to high performing providers can be reduced. The latter might also function as resource persons to back up zonal managers.

3.5.2 Recommendations for EAD

4. EAD should relocate FP/antenatal services at Ruharo within the health unit next door in order to provide a wider range of services, ensure privacy for client counseling and examinations, and improve integration of RHS.

5. A medically trained supervisor (physician or nurse) should be added to the EAD team to complement the skills of the project manager and provide monitoring and training for providers.

6. EAD service providers should be included in all DISH training, especially the Comprehensive RHS Training Program, as an important step in bringing EAD more fully under the DISH umbrella.

7. In light of the concerns expressed as to the quality and impact of the medical student component of EAD, funding for transportation and travel stipends for students and their supervisors should be immediately discontinued.

3.5.3 Recommendations for Both Projects

8. Operations research is recommended (resources permitting) to monitor client loads and devise strategies for continued improvement in management of integrated services and clients with multiple health problems.

9. Integration of messages on FP and STI/HIV prevention should be strengthened through further training and support supervision.

10. Individual FP counseling sessions observed were excessively long. Providers should be re-trained in effective and efficient counseling skills.

11. Newer clinical concepts, such as concurrent use of barrier contraceptive methods with non-barrier methods (e.g., IUDs) for STI prevention or use of OCs for emergency contraception, should be introduced into training curricula and service protocols, preceded by appropriate baseline research. Postabortion care should be fully instituted as part of integrated RHS.

12. Negotiating skills for condom use and STI prevention should be role played during counseling. IEC activities should stress and model male involvement and contraceptive practice.

13. A quality assurance evaluation by a local consultant (but one external to the project) should be conducted six months to one year after the above recommendations have been implemented to determine their effectiveness.

4. COMMUNITY OUTREACH: FLEP AND THE USE OF VHWS

4.1 Introduction

Village health workers are the foundation of the community outreach that has been central to FLEP's success, and they have been the key to community services in Busoga Diocese since the inception of the MSRDP. Their work is mirrored in different ways by EAD's CBDs (see Chapter 5) and by the new cadre of community reproductive health workers providing outreach under the DISH Project. The VHWs, however, provide the most durable model for community workers in Uganda. For this reason, the SOW requested a detailed analysis of the VHW's role, their impact, the obstacles these workers face and, most importantly, the desirability and prospects for ensuring their long-term sustainability.

4.2 Role of the VHW

Within FLEP, the duties of VHWs have included the following:

(1) Mobilizing communities to use health facility services through group talks and other motivational activities.

(2) Developing and communicating appropriate messages, often assisted by IEC teams, to educate communities about FP, HIV/AIDS, STIs, prenatal and postnatal child care, and hygiene.

(3) Conducting regular home visits to provide FP counseling and services, including selling condoms and pills provided by the Social Marketing for Change Project (SOMARC).

(4) Referring clients to health facilities (public and private) for clinical, long-term, and permanent contraceptive methods, treatment and management of side effects, STI diagnosis and treatment, HIV testing and counseling, and AIDS support and care.

(5) Keeping individual records for each client and tracking continued use of FP, including following up clients who do not keep clinic appointments.

VHWs are selected by leaders in their own communities, using criteria suggested by FLEP such as literacy level, communication skills, character, and interest. After an initial two-week training, they receive periodic in-service training and refresher courses. A VHW Training Manual, as well as a FLEP Field Supervisors' Manual, were developed in 1993 to standardize VHW training and supervision. A TOT workshop in 1993 introduced new methods of training and supervision to the zonal managers and CBD supervisors who train and supervise VHWs. Parallel training in

AIDS counseling was held separately by the AIDS Information Centre (AIC) and The AIDS Support Organization (TASO).

VHWs are considered essentially full-time workers. Most are said to work about six hours a day, six days a week. This is in contrast to the part-time CBD agents of EAD and DISH, who work eight to 12 hours a week. VHWs rotate between their villages, surrounding rural areas, and the community health center or clinic where they assist providers and hold IEC sessions with clients. Part of their supervision occurs during clinic rotation.

VHWs are given uniform numerical performance targets for FP activities. The current target is 12 new acceptors per month, but since many factors affect numbers of new and continuing acceptors? size of catchment area, rural/urban setting, effectiveness of IEC, infant mortality rates, seasonal influences? achievement of targets varies widely. This can be demoralizing for VHWs unable to meet standardized targets for reasons beyond their control. Also, no targets are set for VHWs' other informational and referral activities, even though such factors as improved levels of immunization, infant nutrition, oral rehydration therapy (ORT) use, and antenatal and postnatal care all contribute to child survival and thus, indirectly, the acceptance of FP.

4.3 Supervision

VHWs are supervised by a cadre of supervisors, themselves senior health workers. The supervisors meet regularly with VHWs to provide feedback on the quality and level of their activities. Work plans are reviewed and revised as needed. Log books, which record new and continuing users and number and type of contraceptives sold, are reviewed for completeness and accuracy. VHWs also submit their revenues from contraceptive sales and collect new supplies. Supervisors record observations on a checklist, which is kept in a file at the clinic, and work with VHWs to develop plans for improved performance as needed.

4.4 Motivation and Compensation

VHWs and VHW supervisors interviewed by the evaluation team seemed to be on the whole technically competent, well motivated, and well accepted in their communities. Some have been with FLEP for as many as 10 years, unusual for a VHW or CBD program. From interviews in both Busoga and East Ankole Dioceses, it was clear that VHW and CBD veterans were considerably more knowledgeable and self-assured than those with shorter tenure. It can be said, in fact, that FLEP has developed a cadre of "professional VHWs" among its longer-tenured workers.

Until March 1996, VHWs were provided a "transportation allowance" intended to defray costs incurred working in villages away from home. Many have large catchment areas and all must

travel considerable distances. For this reason, each VHW was given a bicycle by the project, but its maintenance was the VHW's responsibility? a significant one given the condition of rural roads. The allowance was intended to help with bicycle maintenance and food costs during travel and not to be viewed as a salary, since VHWs have always been considered volunteers.

At one point, transportation allowances ranged from US$15 to US$27 per month, depending on length of service and on the number of trips and distances traveled by the VHW. But Pathfinder, following USAID's guidance, began cutting back on the higher allowances in 1995, and in March 1996, all travel allowances were discontinued. Only VHWs on the IEC team presently receive compensation.

Since cut-off of the transportation allowance, most VHWs have continued to work, with no compensation other than altruistic satisfaction and what planners characterize as the "prestige rewards" of being associated with a locally appreciated program. But productivity has declined. Four VHW supervisors interviewed reported that rates of new acceptors in their areas had decreased by 50 percent since 1995. All VHWs told the evaluation team that the cut-off had been both unexpected and demoralizing. One practical impact was more and more bicycles became too damaged to use, due to the lack of funds for repairs.

4.5 Other Concerns

While the loss of the transportation allowance and the deterioration of bicycles was the most salient problem for VHWs and their supervisors, they were also concerned by FLEP's inability to resupply items of their VHW "kit" that had fallen into disrepair, such as raincoats and carrying cases.

Other problems cited included negative attitudes about FP and specific contraceptive methods from people in the community, particularly men. Clearly, it takes a certain resilience and persistence to continue to approach recalcitrant and unfriendly people in one's community in order to try and change their attitudes. Women tend to be more receptive to FP, but many feel they need their husbands' permission to use contraception and often do not have their own money to pay for contraceptives. There have been some IEC efforts aimed at overcoming male resistance to FP, as well as to condom use for AIDS/STI prevention, but they need to be expanded.

4.6 Social Marketing

From the beginning, part of Busoga Diocese's development philosophy has been to charge for services and commodities. To provide them for free, it was felt, would create dependency and devalue what was being offered. Accordingly, modest fees were charged for both clinic services

and contraceptives beginning in 1986.

Since early 1994, efforts at cost recovery have come under the umbrella of the SOMARC contraceptive social marketing (CSM) program. Based on the results of its own needs assessment, SOMARC trained VHWs in Busoga Diocese to add a CSM component to their services and began supplying "Protector" condoms and "Pilplan" oral contraceptives to FLEP, as well as to EAD and 14 other Ugandan NGOs. Funds realized contribute to FLEP's cost recovery effort. VHWs do not themselves benefit from contraceptive sales. (EAD CBDs are allowed to keep a small profit.)

Protector is sold for USh 100 (about US$0.10) for a three-pack, Pilplan sells for USh 250 (about US$0.25) for a three-cycle pack. However, not all VHWs are able to sell contraceptives at the recommended price. Clients often claim they have no money and are given the commodities at a reduced or deferred cost. At the same time, VHWs have had some success in selling AIDS/FP audio cassettes for USh 1,500 (about US$1.50), and Protector has all but replaced Sultan as the condom of choice in both Busoga and East Ankole, even though Sultan is considerably less expensive. All of this can be taken as evidence of significant price elasticity in rural Uganda.

SOMARC does not believe that VHWs/CBDs can make enough money through the sale of condoms or pills to earn a living, given the buying power of Ugandans and the continuing low demand. Project personnel estimate that USh 5,000 (US$5) would be the maximum profit that could be made in a month, and this only in areas with high demand and population concentration.

Neither FLEP nor EAD is a social marketing project. CSM involves much more vigorous exploitation of retail channels, mass media promotion and advertising, and many more points of sale. Currently, for political and other reasons, Uganda does not appear ready for this sort of activity. This makes two things clear: (1) the modest marketing activities now going on, especially in rural areas, must be maintained, and (2) FLEP's and EAD's modest advances in cost recovery are no substitute for external support in the near future.

A possible negative effect of the introduction of CSM on the work of VHWs, especially after cessation of the travel allowance, is that they might tend to recommend only methods with potential for generating income (condoms and pills). Such a danger is inherent in the introduction of profit from the sale of some contraceptives and not others. FLEP should explore ways to recognize and reward referrals from VHWs for clinical methods of contraception. Recognition could be in the form of positive feedback during performance evaluations and/or special awards.

Were the travel allowance to be reinstated, its levels could be linked to performance as measured by new acceptors and successful referrals. However, this could make the allowance more of a salary, and both USAID and Pathfinder may prefer dealing with a stipend that is linked to very

real expenses incurred when VHWs are away from home.

4.7 Impact of VHWs on Family Planning and Child Survival

MIS data show that VHWs account for not only the great majority of condom and oral contraceptive sales but between 65 percent and 85 percent of referrals for clinical methods as well. These figures are measured in terms of couple years of protection (CYPs) and are based on analysis of referral data (see Chapter 7).

Part of the role of the VHW relates to preventive/promotive services and referrals related to child survival and hygiene, yet project targets and other emphases of FLEP are primarily on FP. There has been some effort to develop measures related to AIDS/STI, but measuring impact in terms of child survival and hygiene has so far been neglected. A few carefully selected indicators in each service area should be developed to enable a more global assessment of project impact.

4.8 Sustainability of VHWs

4.8.1 Financial Sustainability

According to several analyses of community health worker programs in Africa, most fail even though the concept seems to offer a workable solution to Africa's health problems. They do so for many reasons: poor selection procedures; isolation and lack of adequate supervision; poor resupply systems; confusion over preventive and curative services; lack of support by local communities; conflict with those already providing health services (especially traditional healers); low impact on health; and, most importantly, inability to sustain such programs financially.

The VHW developed under FLEP has overcome many of these problems. Although the reasons for this are not fully understood, certainly it is in part because they received a stipend, and because selection, training, supervision, and resupply have been consistently good. The FLEP VHW has been a relatively low-cost, high output, multi-purpose health worker who stays with the program over time. Despite fears and negative attitudes about contraceptives still prevalent in rural Uganda, VHWs have been effective, with results reflected in steadily growing acceptor and service utilization rates.

At the same time, over the life of FLEP, VHW support has assumed ever-larger budgetary significance. As of March 1996, when allowances were discontinued, there were 169 VHWs active in FLEP, 20 of them supervisors, and the cost for their support had risen to approximately US$45,000 per annum. All of this has given rise to a search for alternatives to direct financial remuneration, alternatives which might lift VHW morale and perpetuate their critical role in

FLEP. Possibilities discussed include the following:

- Incentives such as exemptions from hospital fees and children's school fees; easier access to credit from government financial institutions; annual cash awards for the most productive VHWs (all fraught with political and administrative difficulties)

- Narrowing the VHW role to just contraceptive sales with commissions for each unit sold, i.e., a more purely social marketing approach (unlikely to generate more than US$5 per month per VHW, at most, with serious implications for choice and access to other services)

- Income-generating projects, such as sewing, raising milking cows, etc. (not promising based on experience of other NGOs in Uganda)

- Helping Busoga VHWs form an association that could then approach Village Councils for financial support, using part of locally retained fiscal revenues (again, difficult politically and deals with extremely small sums of available resources)

- Accepting the likelihood of mass attrition and training a new cadre of volunteer, part-time VHWs every two to three years (an option that would lose the value of built-up expertise and experience and the potential for using experienced VHWs as trainers)

No single option, or group of options, would appear to be promising, and it is the conclusion of the evaluation team that the allowances for FLEP VHWs should be reinstated for a defined period of time to make it possible to study their work and motivations more closely and afford the opportunity of comparison with other elements of the DISH experience.

4.8.2 The Importance of Community Participation

Without genuine community interest and involvement, a program such as FLEP cannot be sustainable. Family planning programs in Africa have historically been top-down in planning and administration, with "community participation" limited to the time of start-up. There are many aspects of FLEP, however, that give evidence of a more permanent sort of community participation:

- With VHWs at its core, the project is fully oriented toward rural outreach and does not over-emphasize services to better educated, more urban segments of the population.

- Local communities contribute, financially and with manpower, to construction and maintenance of health units.

- Local leaders participate on health committees and are closely involved in planning, decision making, and generation and use of funds.

- VHWs are locally selected, based on qualifications, commitment, and other appropriate criteria.

- Until the cut-off of funds, allowances paid to VHWs brought some money into rural communities, and thus made a small but direct contribution to poverty alleviation.

The evaluation team sought and obtained enough exposure to a variety of communities and their health facilities to be confident in its conclusion that community involvement, especially as reflected in the selection and support of VHWs, is a strength of FLEP and a key to its continued viability.

4.9 Applying the VHW Experience to DISH

DISH is following a different model from FLEP in its CBD activities. The DISH CRHW is a part-time volunteer working with a narrower range of activities than the VHW. Other experience in Africa suggests that volunteers can work for a period of time if there is good supervision, provision of tangibles such as bicycles and umbrellas, and the promise of some income through social marketing. But such workers tend not to remain with programs in the long run.

For this reason, it seems unwise to discard a model that has worked for 10 years—the FLEP VHW—at least until DISH can prove that the part-time, volunteer model can work in Uganda, possibly with adjustments. For example, it may be that only agents with another, local source of income (e.g., teachers, private midwives, or traditional birth attendants) will be able to stay with a CBD program for more than two to three years, and that this will become a selection criterion. Such a model is noted in the DISH CA, but only as a suggestion.

In short, the evaluation team recommends that an alternative CBD model—the FLEP VHW as originally designed—remains available to DISH and USAID for purposes of study and comparison.

4.10 Recommendations

14. The travel allowance for VHWs should be reinstated, at a level to be determined by Pathfinder and FLEP, for at least two years. The issue should be reassessed at that time in light of (1) findings of a survey on VHW impact on FP, AIDS/STI, and child survival; and (2) results of OR to determine the relative cost-effectiveness of the full-time, compensated VHW versus the part-time, uncompensated CRHW of DISH. Such research

could be expanded to examine the question of VHW compensation in other African countries, using USAID/Washington OR resources.

15. After review of DHS and other studies and discussion with the MOH and DMOs, FLEP should adopt key indicators of impact on child survival that can be easily monitored along with existing family planning targets. Impact in broader areas of MCH will help justify reinstatement of a transportation allowance for VHWs.

16. FLEP and EAD should maintain and, if possible, expand their social marketing activities in rural areas. To date the social marketing activities are modest in design and impact, however, they provide access to services for underserved populations and can serve as a base for more vigorous CSM initiatives in the future.

5. COMMUNITY OUTREACH: THE EAD EXPERIENCE

5.1 Introduction

Although EAD project documents speak of "addressing a community felt need," demand for FP in this region has historically been very low, considerably more so than in Busoga Diocese. Indeed, in the project's first two years (1990-1992), only 20 percent of CYP targets were achieved. One project report suggests that the original contraceptive targets were unrealistic for a project operating in "virgin" territory where ignorance and pronatalism prevail.

While EAD was in part based on the FLEP model, its impact to date has been less substantial. The evaluation team feels continued support for EAD is warranted, principally because it brings some level of primary health care to a region where access is severely limited. It sees no justification, however, for EAD to pursue a CBD model that diverges from the DISH model. The team feels that EAD should be brought fully under DISH as soon as possible.

5.2 Function and Problems of CBDs

EAD currently has 57 CBDs, more than half recruited in the past 18 months. As in Busoga, EAD provides guidelines for selection (literacy, numeracy, good character, and communications skills). CBDs are locally chosen by village leaders after public discussion. Project training, presented in two phases, provides them with basic elements of FP, HIV/AIDS, STIs, referral procedures, IEC materials, record keeping, community relations, and? since April 1996? aspects of social marketing. The evaluation team's general impression was similar to that in Busoga: CBDs with long tenure are more knowledgeable and self-assured than shorter-term workers. CBDs who had recently completed their initial training seemed inadequately prepared to begin their duties.

CBDs are part-time agents. They usually work two to three days per week for two to three hours each day, and a half day on Saturday or Sunday when they hold their group talks. About half have separate income, whether regular jobs, such as teachers or private midwives, or part-time work, such as nursing aides or agricultural assistants. This too differs from FLEP, where most VHWs received income only from the project.

As in Busoga, CBDs conduct home visits, counsel for contraception and prevention of AIDS/STIs, sell pills and condoms, and refer clients to health facilities for IUDs, VSC, and other clinical methods. Until their allowances were also discontinued, they were paid USh 20,000 (US$20) per month for meals in the field and bicycle maintenance. They received a bicycle, gum boots, T-shirt, umbrella, and a kit for carrying commodities and informational materials.

Following a directive from Pathfinder, EAD phased out CBD allowances between September 1995 and March 1996. Five CBDs have resigned so far, with more expected to leave the project. Those remaining have become less active, because they have not been able to keep their bicycles in order, are less motivated, and/or have had to spend more time in subsistence activities. Some cost recovery from social marketing exists, but profits are minuscule.

Other problems cited included negative attitudes about FP in general and objections to specific contraceptive methods from people in the community, particularly men. These were mentioned as obstacles by the VHWs of FLEP as well, but motivating contraceptive use in East Ankole Diocese seems an unusually slow, uphill battle.

5.3 Conclusions

The team urges that EAD be fully integrated into DISH. It does not recommend reinstatement of a regular allowance for its CBDs, since this does not conform to the DISH model of community outreach. On the other hand, being a full participant in DISH will enable EAD to take full advantage of DISH training and have access to DISH print and other materials for use in its IEC efforts, heretofore rather fragmentary.

There will certainly be turnover in CBDs, notably those who cannot adjust to the passing of their stipends. But the project is young enough to adjust. It also brings useful experiences with it, such as the modest success with CBDs who are less than full-time and have other sources of income. If this variation continues to show promise (the evaluation team was unable to gather sufficient data to make a definitive judgment either way), it might be adopted in some form by DISH as a whole.

5.4 Recommendation

17. In keeping with other, more specific recommendations, integrate EAD fully, in both the administrative and programmatic sense, into the larger DISH Project, enabling it to benefit fully from DISH training and other resources.

6. INFORMATION, EDUCATION, AND COMMUNICATION

6.1 Introduction

The SOW requested that the evaluation team make a detailed assessment of the quality and impact of the IEC component of the two projects. Because FLEP IEC activity was far more developed, both in terms of strategy and output, the team focused most of its analysis there. Indeed, EAD's modest IEC activity consisted primarily of using materials developed by or for FLEP, so an evaluation of one can be perceived as covering both.

6.2 Development of FLEP's IEC Strategy

FLEP has an IEC team of VHWs and VHW supervisors with special talent and interest in IEC. The team is supplemented by zonal IEC teams in developing strategies and materials. In the project's early years, this process consisted largely of trial and error. As IEC team members developed messages for particular target audiences, they learned which ones were appropriate from feedback gathered in the community.

After several years of experience in bringing FP (and more recently, AIDS and STI prevention) messages to rural Ugandans, FLEP concluded that print and electronic media, used alone, were too one-sided and did not permit people to ask questions that spoke to their special needs. Family planning and AIDS/STIs are highly sensitive topics that cannot easily be addressed directly in Ugandan culture. Yet these topics could be approached indirectly through drama, song, and other traditional Ugandan forms of expression and entertainment.

By 1993, FLEP's IEC emphasis had shifted to face-to-face health education supported by print materials and weekly radio programs. Much of its programmatic attention has been devoted to contradicting rumors, everything from "the pill causes abnormal births" to "the condom can get lost in a woman." VHWs confirm that rumors tend to accompany any innovation in Uganda, which only adds to the evidence that acceptance of FP is still a slow process. The team found FLEP's overall IEC program both comprehensive and attuned to this reality.

6.3 Face-to-Face Health Education

Where FLEP's IEC seems especially strong is in direct health education in villages, schools, or other public venues through what it calls the "Enter-Educate" approach. The IEC team performs combinations of drama, dance, music, and song, usually drawing large, diverse audiences. One VHW explained that drama and song "makes people happy" and receptive to learn. It also draws crowds. A sample skit called "Too Early" teaches about the consequences of a teen-age girl

becoming pregnant. Others highlight the conditions that contribute to maternal mortality: "too early, too soon, too many, too old."

After each performance, IEC team members ask the audience what they saw, what they learned, and what questions they still have. When a skit is new, a standard Assessment Guide is used by VHWs to determine overall comprehension, elements liked and disliked, ways to improve the performance, and thoughts about its length, content, and suitability of venue. However, there has apparently been no such evaluation of retention of messages after a period of time has elapsed.

An IEC report for April 1996 indicates that over 13,500 people were exposed to this type of health education in 45 project areas served by FLEP. Crowds were large and diverse, although women of reproductive age (WRA) and children predominated. At presentations observed by the evaluation team, Christian and Muslim clergy, village chiefs, and other local leaders were present and actively engaged.

Costs associated with this activity depend on the size and makeup of the team involved and time spent in the field. Fielding a large group of VHWs from the central IEC team can cost about US$200 per day for all costs, including performances, follow-up questions and answers, individual counseling, and contraceptive sales. (By comparison, in Mozambique it costs about US$100 to put on a single one- to two-hour health education performance in a village, including vehicle and fuel costs but excluding overnight or other expenses.) Smaller, zonal IEC teams, with less central input, can put on less elaborate programs for about US$40 per day.

Before replicating this approach, which would appear to be well-suited to rural Uganda, there should be OR to link the cost of these IEC efforts to changes in knowledge and attitudes and, especially, contraceptive practice, whether for FP or disease prevention.

6.4 Print Materials

Little original print material has been developed by FLEP; rather, such materials have been obtained from the MOH, the Family Planning Association of Uganda (FPAU), other NGOs, and international organizations, by whom they have been pre-tested. FLEP then used project funds to reproduce those materials found to be appropriate for its needs. This approach can be an asset from the standpoint of conserving resources, as long as the material is appropriate for the intended audience(s).

As a result of this approach, FLEP was able to focus its scarce resources on developing a series of short leaflets on problem areas that it felt were not well covered by existing materials. The leaflets, however, were not pre-tested before being put into circulation. Simple focus groups for this purpose would seem to be an easy and almost cost-free addition to the IEC program.

All in all, it is to FLEP's credit that project resources have been directed to areas of greatest programmatic need, without duplication of existing materials, which often happens in similar projects.

6.5 Quarterly Newsletter

Until recently, FLEP published a quarterly newsletter called "Wali Okimanyi?" ("Did You Know?"). It was created to (1) increase communication between project areas, disseminating lessons learned about what does and does not work and (2) educate the local population about FP and contraception. FLEP knew that men needed to learn about the latter, yet were a difficult audience to reach. Men are more likely to be literate than women, however, and eagerly read newspapers available in Busoga Diocese. Thus, it was hoped that men in particular would read the newsletter.

The newsletter's content, however, seems to have been too sophisticated for rural villagers. The subject matter was clearly pitched to mid- and upper-level staff working in health and development, rather than a broader rural population. The newsletter was also a financial liability. While VHWs sold it for USh 100 (about US$0.10) a copy, it cost the project USh 600 (about US$0.60) per copy to produce. The newsletter was discontinued in 1995, both to cut costs and in recognition that recently introduced DISH publications ("Health Matters" and "Straight Talk") were more successful in striking a tone that appealed to a wide audience.

6.6 Radio and Audio Cassettes

Since 1990, radio was regularly used by FLEP as a secondary message medium. VHWs say that people tend to be in awe of, and believe, things they hear on the radio. As a result, for several years FLEP aired a 15-minute radio program, developed by the IEC team, every Thursday. The team records their most popular songs, musical sketches, and dramatic skits in the Lusoga language. After capturing the attention of the listener, the cassette proceeds to dialogue, questions and answers, and other more direct health and FP education.

The cassettes are sent to Radio Uganda in Kampala for airing on a channel that covers southeastern Uganda. The station charges FLEP about USh 750,000 (about US$750) for three months of weekly broadcasts. This comes to only US$62.50 per week, making this a particularly cost-effective way of reaching large audiences with FP and AIDS/STI messages in a manner that is culturally appropriate. Unfortunately, funds for radio programming have not been available to the project for about a year.

6.7 IEC in Schools

Although articulation of a 1995 national policy on sex education in schools no doubt made it easier to educate youth, FLEP deserves considerable credit for tackling this difficult issue. It has brought information and education about AIDS, STIs, and FP to teenagers and younger school children, often in the face of opposition from teachers and parents. The FLEP school program uses an entertaining style to target its audiences with youth-oriented messages and music. It provides forthright condom information and attempts to educate teachers as well.

FLEP also shows videotapes of VHWs' music/drama performances in those schools to which the IEC team can easily transport its equipment. Films such as "Consequences" (a teen pregnancy educational film well known throughout Africa) are also shown to school audiences.

6.8 Integration of Family Planning and AIDS/STI Messages

According to VHW supervisors, the introduction of AIDS/STI services has helped in the promotion of FP. For example, men who resisted using contraceptives for FP will listen when their disease prevention function is explained, as in the case of condoms and foaming tablets.

The Enter-Educate approach focuses primarily on FP and STI/HIV issues in a variety of combinations. Some skits and songs are primarily about FP or about AIDS. Others combine the two equally.

Some problems in the integration of the two services have also been noted. People may become defensive if the topic of AIDS or STIs is raised during a discussion of child spacing ("Why do you mention this? Do you think I am sick?"). Furthermore it can be difficult for VHWs to discuss sexual behavior with people who come from the same community and thus are known to the VHW. Finally, as described in an earlier chapter, the evaluation team found few instances of dual protection (i.e., methods for FP and STI prevention) being advised.

6.9 Strengths, Weaknesses, and Impact of IEC

Notwithstanding their vigor and quality, it is not clear what overall impact FLEP's IEC initiatives have had to date, either singly or as a whole. This is largely because, as Table 2 indicates, FLEP IEC has been long on action and short on the evaluation of impact. For example, while it appears that intensive face-to-face education and radio IEC have been a factor in the subsequent increase in new acceptors, there has as yet been no systematic analysis of cause and effect.

As its recommendations reflect, the evaluation team commends FLEP on the substance, relative low cost, and community focus of its IEC effort, however, it urges heightened attention, possibly

with the help of external technical assistance, to a careful assessment of what it has accomplished and its cost-effectiveness. A thorough understanding of the hows and whys of FLEP IEC, not to mention a comparison with the far more modest IEC effort under EAD, will pay significant dividends in refining the IEC approaches of DISH.

Table 2

Strengths and Weaknesses of FLEP's IEC Component

RELATIVE STRENGTHS	RELATIVE WEAKNESSES
? Face-to-face, entertainment-oriented IEC component well developed ? Segmentation of target audience (teens, drop-outs, elders, women, men) ? Tailoring of messages to special groups (e.g., disco and rap music for teens) ? Appropriate school-based sex education, FP, and AIDS/STI prevention ? Low-cost radio shows seem cost-effective ? Appropriate, limited development of print materials only where there is an unmet need	? No formative research to serve as ? No pre-testing of print materials ? Some methods basic to IEC testing, cognized ? Little use of technical consultants ? No evaluation of IEC for retention of

Source: Evaluation team observations.

6.10 Recommendations

18. Operations research should be conducted to assess the impact and cost-effectiveness of FLEP's face-to-face, entertainment-oriented approach to IEC in various settings, including schools, in terms of changes in knowledge, attitudes, and contraceptive usage for family planning and disease prevention.

19. If funds can be found, FLEP radio broadcasts should be reinstated and a listener survey conducted to determine comprehension, message recall, and evidence of behavior change.

20. Focus groups should be convened, if possible for little or no cost, to assess the quality of and receptivity to FLEP's own informational leaflets.

21. If the suggested assessments so warrant, size of IEC teams should be scaled back to free up FLEP personnel to serve as IEC trainers for the DISH Project. Senior VHW IEC team members with in-service training skills might also be hired by local NGOs and international health organizations to conduct IEC training.

22. A concerted effort should be made to identify specific elements of IEC (training, performances, sale of cassettes) that could generate income for FLEP's IEC activities, if not its broader program. Technical assistance in this area should identify which components and activities to develop and how to market specific services and materials.

7. DEMOGRAPHIC ISSUES

7.1 Introduction

The evaluation SOW posed several questions related to the demographic impact of FLEP and EAD:

- Is the estimated contraceptive prevalence in FLEP project areas accurate, and has it been properly calculated by reasonable means?
- If not, how should methods of estimation be revised, and what is actual prevalence likely to be?
- Is it possible or useful to estimate CYPs by method, age, and parity?
- Can FLEP's impact in terms of fertility and population growth rates be estimated?
- Can prevalence be estimated at all in East Ankole?

This chapter addresses these questions, reviews project performance, and makes recommendations for improved demographic estimates.

7.2 Project Performance

7.2.1 FLEP

Figure 1 and Table 3 display FLEP FP performance during the third phase of project activity for the period November 1992 to March 1996. Activity was consistently high during the first 10 quarters with revisits ranging between 4,000 and 6,000 per quarter and new clients following a similar pattern. A peak in activity during quarters four and five is attributed to the effects of adding aggressive IEC efforts to the project during late 1993. Since early 1995 (quarter 10) the project shows a gradual but consistent decline in performance. In large part this may be because the months since early 1995 have been tumultuous for FLEP. The original project manager took other employment; the acting manager assumed responsibility, on an acting basis, without having been fully prepared; a diocesan crisis among Anglican leaders flared; VHW allowances were eliminated; and several service providers left, due to non-payment of salaries and the expectation of better pay in the public sector.

Insert Figure 1

Table 3

Trends in Family Planning Indicators (FLEP Performance, Phase 3)

Dates	Quarter	CYPs	New Clients	Revisits
Nov-Jan 93	1	3,345	2,845	4,022
Feb-Apr 93	2	3,877	4,690	5,393
May-Jul 93	3	4,523	3,726	5,552
Aug-Oct 93	4	8,740	6,075	5,840
Nov-Jan 94	5	9,347	6,615	6,352
Feb-Apr 94	6	7,664	6,752	5,322
May-Jun 94	7	5,381	4,759	4,428
Jul-Sep 94	8	6,375	5,194	6,591
Oct-Dec 94	9	5,653	4,115	7,046
Jan-Mar 95	10	6,574	5,705	5,116
Apr-Jun 95	11	5,171	4,363	4,311
Jul-Sep 95	12	4,222	3,401	4,141
Oct-Dec 95	13	4,629	3,156	4,104
Jan-Mar 96	14	3,617	2,682	3,915
Total		79,118	64,078	72,133

Sources: FLEP Quarterly Report: District Performance Tables, 1994, 1995, 1996; FLEP MIS.

7.2.2 EAD

Figure 2 and Table 4 show the performance of EAD during the period January 1993 to March 1996 (quarters 1 through 13 of the project's second funding phase). Performance in recruiting new clients has remained consistent during the project period. (Because EAD is a much smaller project both in terms of manpower and physical resources, the levels achieved are noticeably lower than those of FLEP. Therefore, the two projects should not be compared with these indicators.) The project shows a high rate of revisits, implying retention of clients not using permanent or long-term methods. As discussed below (Section 7.4), the program relies heavily on Depo-Provera, a method that requires regular revisits and generally has fewer drop-outs than supply methods like pills or condoms.

Insert Figure 2

Table 4

Trends in Family Planning Indicators (EAD Performance, Phase 2)

Dates	Quarter	CYPs	New Clients	Revisits
Jan-Mar 93	1	672.0	1,295	637
Apr-Jun 93	2	913.0	897	907
Jul-Sep 93	3	951.1	606	931
Oct-Dec 93	4	632.7	444	906
Jan-Mar 94	5	560.3	436	949
Apr-Jun 94	6	684.4	554	973
Jul-Sep 94	7	765.5	564	1,068
Oct-Dec 94	8	782.2	404	1,130
Jan-Mar 95	9	811.5	490	1,149
Apr-Jun 95	10	820.0	515	1,283
Jul-Sep 95	11	947.1	611	1,312
Oct-Dec 95	12	840.1	467	1,329
Jan-Mar 96	13	796.2	435	1,257
Total		10,176.1	7,718	13,831

Source: EAD Quarterly Programmatic Reports.

7.3 Contraceptive Prevalence: FLEP

It is difficult to assess the contraceptive and fertility impact of FLEP using existing data sources, because no baseline study was done at the time the project began. However, given that FP services were available in only a few urban areas in Jinja and Iganga districts through FPAU, it is likely that contraceptive prevalence was extremely low. National estimates reported in the 1988/89 Demographic and Health Survey (DHS) found a CPR of 5.5 percent for all women, with only 2.7 percent reporting current use of a modern method. An internal evaluation of FLEP conducted in 1988, after two years of project operation, found a CPR of 9.4 percent (all methods) among 307 surveyed women living in the communities in which FLEP was active, and 5.9 percent reported using modern methods (Kisubi, et al., 1988).

An internal evaluation was again carried out to assess performance during the second phase of the project for the 18-month period ending October 1990 (Kisubi, 1991). Using estimates of the target population of WRA along with the number of clients recorded, a CPR of 14.7 percent was estimated for 19 service delivery areas. Since client records record women using modern contraceptives, this implies a tremendous increase in contraceptive use from the survey estimate of two years earlier. It is also probably an overestimation, as the report author notes that "the calculation of the rates did not take into account the drop-outs in the first quarter.... These figures need to be reworked out (sic) when satisfactory drop-out figures are available" (Kisubi, 1991:5). The evaluation team did not find evidence that the adjusted calculation was made.

The end-of-project evaluation carried out in mid-1995 (Shumba, 1995) reports a modern CPR of 18.2 percent among respondents in 16 project sites. While this figure is consistent with the general pattern of increased contraceptive use shown in earlier surveys and service statistics, as well as the national rate (14.8 percent) presented in the preliminary report of the 1995 Uganda Demographic and Health Survey (UDHS), the report of the evaluation findings is seriously flawed and calls into question the reliability of this estimate. Apparent errors include the following:

- A total CPR is not presented by method, making it impossible to determine the relative contribution of specific modern and traditional methods.

- The contraceptive method mix reported omits IUDs, one of the most popular methods used in the program.

- Only 17 percent of respondents reported knowing condoms as a FP method, a decline from the 55.4 percent reporting knowledge of this method in 1988.

- For at least one project area, current use of contraception exceeds ever use.

- Mawundo, reporting the lowest area CPR (3.4 percent), was estimated to have the highest CPR in 1990 (50.1 percent) using service statistics.

Some anomalies, such as the low awareness of condoms, appear to be a function of the way interviewers posed questions to respondents. In this case, respondents offered methods they knew and were not probed for others. If a woman reported knowing one or two methods, the interviewer typically moved on to the next question without eliciting additional information. For such cases, the report should provide the reader with an explanation of atypical findings. Other discrepancies seem to be the result of inaccurate coding or table construction. Selected variables were reanalyzed as part of this evaluation and showed enough problems to warrant discarding the data.

A major inhibiting factor in assessing project impact is that no proper catchment area survey or mapping exercise has ever been carried out, making it virtually impossible to know the size of the population affected by FLEP activities.[1] This in turn makes it difficult to reliably use the program service statistics as an alternative data source for estimating the CPR. Nevertheless, a crude calculation can be made using an approximation of the service delivery area. Given a total population in the project area of about 550,000 and about 23 percent of the total is WRA,[1] the main service target is 126,500 women. As of 30 April 1996, FLEP recorded 30,140 active contraceptive users, or 23.8 percent of the 126,500 women. If condoms (6,702 users) are excluded from the method mix on the assumption that they are used more often for protection against STIs than for FP purposes, the number of active users is 23,438, or 18.5 percent of the WRA. This provides an alternate estimate of project performance.[2]

Nevertheless, because the survey data are weak and the estimate using service statistics may vary greatly if the catchment area was better defined, neither estimate should be cited as a definite indicator of program performance. The evaluation team recommends that a new survey be undertaken to more effectively gauge the impact of FLEP. The survey should be approximately the same size as the previous effort (about 800 women), with the sample split so that half the women interviewed are from project sites and half from other sites within Busoga Diocese. This strategy will permit analysis of the data in the context of the overall health and FP environment in the project area. It is less important to obtain estimates of contraceptive use for the individual project service delivery sites, particularly given that the sample sizes for the small geographic areas are too small to be statistically stable.

The proposed survey sample size will also be large enough to calculate CPRs for women in different age groups and of different parities, important information for effective program planning and target setting. A recent analysis of client characteristics using 2,014 FLEP client cards showed that most women had experienced six pregnancies; 17.5 percent reported more than 10. The mean age of women using the pill was 25; injections, 29; tubal ligation (TL), 34 (a full cross-tabulation of method mix by age was not included). Additional study of client characteristics would be useful in segmenting the population for specific project interventions.

7.4 Contraceptive Prevalence: EAD

The same type of analysis yields a very low CPR for the EAD project area. A catchment area population of 330,000 implies 75,900 WRA. The project recorded 2,229 active users for the first quarter of 1996, for a CPR of 2.9 percent. This is appreciably lower than the level recorded in

[1] The proportion recommended by the MOH to estimate the local area FP target populations (van Damme et al., n.d.).

[2] While calculating the CPR from service statistics on users and estimates of the population at risk is possible, the preferred method is to use data from population-based sample surveys. This minimizes problems associated with maintaining accurate counts of current users and estimating target populations.

DISH Area I (districts of Kasese, Mbarara, and Ntungamo) by the UDHS (5.7 percent for modern methods) and warrants further investigation.

7.5 Contraceptive Method Mix

Depo-Provera dominates the method mix for FLEP (Table 5). One quarter of all active users have selected this method, evidently for its ease and discretion of use. More than 20 percent of users have chosen condoms, but it is not known if they are being used for contraception or as prophylaxis against STIs. This is twice the level reported in the preliminary UDHS and likely reflects the emphasis on community distribution by VHWs. Nearly equal shares of users have selected oral contraceptives (15 percent), IUDs (14 percent), and TLs (14.8 percent). The extent of TL use is notable; the level achieved in Busoga Diocese in particular and Uganda in general, according to the preliminary DHS data, is very high by African standards. (Recent surveys in Tanzania, Rwanda, Malawi, and Zimbabwe found only 2.3 percent of married women reporting use of TL.) FLEP clients are three times more likely to choose an IUD than are Ugandan women as a whole. While it is desirable to have a range of methods available and to emphasize long-term methods, the use of IUDs without barrier protection must be considered carefully given the high incidence of STIs in Uganda.

The reliance on Depo-Provera in EAD is even more extreme. As of early 1996, half of all active users relied on this method. More than one third used the pill, close to the proportion reported in the UDHS. About eight percent used condoms, slightly less than national levels. In contrast to Busoga, EAD shows a very limited use of long-term and permanent methods, with fewer than two percent of users choosing IUD, NORPLANT?, or VSC.

7.6 Couple Years of Protection

Both FLEP and EAD report CYPs as an indicator of the volume of program activity. They are not calculated to show their distribution by age or parity because this is not a measure of individuals. Rather, CYP conversion factors are used to translate commodities distributed and clinical procedures performed into an estimate of contraceptive protection during one year.

Table 5

Contraceptive Method Mix among FLEP and EAD Active Users and UDHS Current Users, 1995 (%)

Method	Active Users: FLEP 30 April 1996	Active Users: EAD January-March 1996	Current Users: UDHS (currently married)
Pill	15.0	36.6	33.3
Condom	22.2	7.9	10.3
Jelly	2.8	2.7	
Foaming Tabs	4.6	1.2	1.3
Depo-Provera	25.9	49.8	32.0
IUD	14.0	0.4	5.3
Tubal Ligation	14.8	1.2	18.0
Vasectomy	0.5	0.0	0.0
NORPLANT?	0.2	0.2	0.0
TOTAL	100.0	100.0	100.2*

Sources: FLEP "Active Users by Method as of 30th April 1996"; team calculations of DHS data from Uganda DHS Preliminary Report, 1995, Table 4; EAD "Count and Percentage Distribution of Active Users from January 1994 to March 1996."

***** Does not add up due to rounding.

FLEP began using CYP as a program performance indicator in 1990. Results reported after 18 months showed that CYPs produced were greatly skewed by the considerable use of voluntary sterilization. While VSC clients accounted for 13 percent of new clients served, they accounted for 67 percent of all CYPs (Kisubi, 1991). In contrast, methods provided directly by the VHWs (pills, condoms, foaming tablets) accounted for only 18 percent of all CYPs. CYP is a poor measure of CBD performance, given the high volume of commodities that must be distributed to achieve a single CYP for pill, condom, and foaming tablet users (13, 150, and 150 units respectively). Indeed, if CYPs generated by both projects' VHWs and CBDs are disaggregated, they show that FLEP VHWs generate slightly more than one CYP monthly, while EAD's CBDs generate slightly less than one. FLEP VHW referrals contribute the lion's share of clinical CYPs (Table 6).

EAD reports from the first quarters of 1994, 1995, and 1996 show that CBDs made between 126 and 273 referrals for clinical methods per quarter, an average of four to nine each. Comparison of summaries for CBDs and outreach services present a less clear picture. CBD referrals for a given quarter may range from 50 percent to 100 percent of new clients seen for different clinical methods. At the same time, the columns for confirmed CBD referrals are almost always blank in quarterly reports. Thus there is no way to verify the actual level and impact of CBD referrals on total project performance.

Table 6

FLEP VHW Referral CYPs by Method as Percentage of Total Program CYP

	VHW Referral CYPs as Percentage of Total			
Method	Oct-Dec 1994 Quarter 9	Jan-Mar 1995 Quarter 10	Apr-Jun 1995 Quarter 11	Jul-Sep 1995 Quarter 12
Tubal Ligation	84.8	92.9	72.8	83.2
IUD	65.0	82.6	88.2	88.4
NORPLANT?	23.3	59.9	66.2	66.0

Source: FLEP service records.

7.7 Fertility Impact

Lack of baseline data, questionable catchment area estimates, and time-referenced fertility data make it difficult to estimate FLEP's and EAD's impact on fertility. The data required to calculate total and age-specific fertility rates are not available. Once a new survey is completed, if data are collected on all sources of FP methods, births averted due to program activities can be computed.[2]

Overall, the fertility impact is likely to be negligible until the profile of contraceptors changes. As noted above, women using FLEP services have high parity and begin using long-term methods at older ages. A study of 304 new acceptors in EAD showed that 52 percent had at least four children and 22 percent had seven or more (Kambagira, n.d.); 75 percent had married by the age of 19, implying an early onset of childbearing.

In preparation for suggested studies, as well as for qualitative and OR that will yield deeper and

more detailed information on program performance and quality, all service delivery points should be surveyed to construct a map of communities served by health units, VHWs or CBDs, and MOH facilities. Then, using adjusted 1991 Census figures, the population included in these areas should be calculated. Both exercises should be completed by the end of 1996.[3] While Pathfinder possesses the expertise to undertake this exercise, staff time constraints may make it desirable to hire a local consultant to help develop research plans.

The evaluation team understands that it is proposing new research initiatives at a time when financial resources are in short supply. If the fertility impact of FLEP and EAD are to be accurately understood, however, their statistical base must be improved.

7.8 Recommendations

23. A new FLEP survey should be undertaken, along lines suggested in the text, to more accurately assess program impact in project areas in terms of primary health care, STI treatment, child survival, as well as family planning.

24. Catchment areas of both FLEP and EAD should be reviewed and, where necessary, more clearly defined in order to provide a map from which more reliable measures of coverage and impact can be estimated.

[3] A guide to estimating service areas is available from the MOH Health Planning Unit: van Damme, et al., Rapid assessment method for service populations, n.d.

8. HEALTH INFORMATION SYSTEMS

8.1 Status of Project Systems

Questions included in the SOW regarding FLEP and EAD project information systems include the following:

- Do the projects' management information systems routinely provide data that are sufficient and accurate to manage the projects effectively and measure their achievements?
- What improvements in the MIS are indicated?
- Is there sufficient emphasis on the collection and use of "soft" data on service quality and client satisfaction?

Both FLEP and EAD maintain good information systems. Monthly reports are submitted from VHWs and health units, in the case of FLEP, and CBDs and clinical outreach workers for EAD. Records are admirably complete, with the majority of reporting points in both projects submitting summary reports in a timely way. Reports were less complete for the quarter immediately preceding the evaluation, which was attributed to reduced morale resulting from the aforementioned cuts in VHW and CBD allowances.

Spot checks of VHW and health unit register books generally showed accurate tallies for each month. Some mistakes were observed, mainly in addition or in the exclusion of some methods in the tally for continuing users. Supervisors should make sure that they check provider tallies routinely during their visits and advise VHWs to record each method in the same sequence each month. This will reduce the likelihood of individual methods being omitted.

The report forms seem easy to use; service providers appeared comfortable in completing the forms and did not express any objections to filling them out. The Family Planning Register used in the fixed facilities follows the recommended format of the Register of the MOH health information system (HMIS 074), reducing (although not eliminating altogether) the burden of reporting the same information on multiple forms to different sources (Ministry of Health, 1996).

Data collected from service providers are entered onto spreadsheets for monthly totals and subsequently combined for quarterly reports. The reports produced are used by management to track program performance and complete quarterly reports submitted to Pathfinder International. Both projects utilize the graphing capabilities of their software to generate attractive and informative charts of program performance. The bar charts of individual CBD performance produced by EAD are a particularly useful tool in identifying consistently poor performers.

8.2 Data Use

Program managers cited a number of different applications for the data generated, including assessing the performance of individual service providers, targeting supervision efforts, redeployment of CBDs, and identification of problems in overall project implementation. Nevertheless, both projects need to spend more time analyzing the data they produce. FLEP is particularly hampered in this regard, as its program analyst position has been vacant since December 1994. Staff members cite both the unattractive salary package and erosion of the position's budget as reasons that the position is unfilled. A data entry clerk maintains the information system and is comfortable enough with the spreadsheet software to create and modify new forms, tables, and graphs. However, the incumbent needs to develop skills to analyze the data produced and highlight changes for the program managers. Evidently the FLEP Board of Trustees has considered modifying the program analyst position to incorporate both information management and resource mobilization. This is a reasonable plan, and efforts should be made to proceed with the recruitment process.

EAD has a well-trained analyst in place. He has a Masters Degree in demography from Makerere University, had computer skills before joining the program, and feels comfortable with interpreting the patterns evident in the data. He serves as a deputy to the project manager and reviews reports with him and other staff members on a routine basis.

Few improvements are indicated for the MISs. There are a number of forms for which column or row percentages, or absolute numbers, should be added to facilitate interpretation (see suggested modifications in Table 7). Neither project has a user manual for its system, and thus each relies heavily on the clerk and analyst to produce all reports. EAD does not have a manual for the software used (Quattro-Pro).

8.3 Target Setting

One puzzling aspect of this evaluation was the use of targets. Generally, targets serve three purposes: planning a program; motivating staff; and guiding the monitoring and evaluation process. For FLEP and EAD, targets are mainly used to design the initial and follow-on programs and monitor staff performance.

Both FLEP and EAD had ambitious targets set for program performance. (Indeed, staff members of both projects mentioned that targets proposed in Uganda were increased after review by Pathfinder International in Boston.) Both projects distribute annual targets to providers. All service providers in the respective cadres are given the same targets, regardless of population density in the catchment area, travel requirements, or proximity to a district health facility. All

Busoga Diocese health units visited had a chart posted of achievements graphed against the monthly targets. In most cases, actual performance fell well below the monthly goal, often reaching only 40 percent of the expected level.

Table 7

Reports Used and Suggested Modifications

Report Form	Suggested Action
FLEP: Total Quantities and CYPs by VHWs	Add number of VHWs reporting. Calculate non-response rate.
FLEP: Active Users by Method	Calculate column percents to indicate relative contribution of each method.
FLEP: Total Quantities and CYPs for Practitioners and VHWs	Calculate percent of total CYPs generated by VHWs and practitioners.
EAD: CBD Monthly Report Form	Add total new clients for all methods, total new acceptors, total revisits, total referrals. Add number of CBDs reporting. Calculate non-response rate.
EAD: CBD Quarterly Reporting Form	Calculate average revisits, new clients, new acceptors, home visits for all CBDs reporting.
EAD: Quarterly Summary Form	Add NORPLANT? to CYP calculation page. Calculate percent of new clients, revisits, new acceptors generated by Ruharo and by all others sites combined.

Source: Evaluation team observations.

In a curious illustration of the elusive use of targets, FLEP supervisory reports for the eighth, ninth, and eleventh quarters of Phase 3 each listed quarterly targets of 9,800 CYPs, 4,320 new clients, 5,184 home visits, and 1,296 group talks. CYPs achieved for each of the eight project zones were listed, together with their percent of target. In each of the three quarters, the denominator used to calculate the total was different (though it appears to be around 960 and differences observed may be a function of rounding), and in no case did the denominators sum to 9800. The reports indicated that individual zones achieved between 54 percent and 113 percent of the quarterly targets. This seems difficult to reconcile with the uniformly low achievements observed at most health units.

It appears that the main use of targets for both FLEP and EAD lies in the evaluation of individual and service delivery site performance, relative to others in the program. Those who consistently fall below the average indicated by the best and worst performers are investigated to determine what factors affected achievements: inadequate training, poor weather, seasonal variations in agricultural labor, personal constraints, or other variables. In the FLEP Phase 2, performance was linked to some rewards, such as blankets or lanterns, but these incentives were not included in Phase 3. It does not appear that VHWs or CBDs suffer any sanctions if they consistently fall below their targets.

8.4 Qualitative Data Collection

Neither project has invested in qualitative research to assess quality of care or client satisfaction to date. Given that EAD has operated for five years and FLEP for 10, and that both are about to undertake proposal development for follow-on activities, it is an opportune time to undertake some in-depth study of relevant concerns, as described above and in previous sections on quality of care, VHWs, and IEC. These studies need not be complex nor large in scale. Much can be learned using focus groups, rapid assessments, client exit interviews, and well prepared OR designs.

8.5 Recommendations

25. Both projects should develop simple, easy-to-use user manuals with instructions on how to input data, perform calculations, and generate reports from their data systems. These should include step-by-step instructions for accessing files and templates and examples of the tables and graphs produced.

26. Greater effort should be made to tailor targets to the individual service delivery areas based on criteria such as catchment area population size, current CPR, or proximity to alternative sources of services. Targets should be regularly reviewed and revised as necessary to conform to changing realities in the particular areas to which they apply.

9. ORGANIZATIONAL DEVELOPMENT AND MANAGEMENT

9.1 FLEP: Structuring for Sustainability

9.1.1 Strategic Plan

The evaluation team assessed FLEP's organizational structure and strategies in the context of the organization's planning for financial sustainability (discussed in Chapter 10). It did so by talking at length with management and technical staff, both past and present, and with several members of the Board of Trustees. The team also reviewed FLEP's draft "Five-Year Strategic and Sustainability Plans 1996-2000," prepared by project staff and the Board's Subcommittee on Strategic Planning, with assistance from the Pathfinder Regional Office in Nairobi. The document was still awaiting review and ratification by the full Board.

The plan lays out goals, objectives, and activities in five key areas: enhancement of Board governance, strengthening FLEP's institutional capacity and structure, improving FLEP's service delivery, improving community outreach and involvement, and creating a resource development strategy and sustainability plan. The team was impressed by the sophistication and detail of the document but was concerned with its presentation of long, not particularly individualized lists of tasks and objectives without, perhaps, a full examination of their practicality.

For example, the draft strategy places what the team found to be excessive focus on expanding services? even adding new ones? rather than streamlining and increasing efficiency in the delivery of existing services. While this is clearly, and commendably, a reflection of the Board's commitment and ambition, it seems unrealistic in light of funding realities. Rather, while a long-term financial sustainability plan is being discussed and developed, the Board and management would do well to look at ways to consolidate and make the best use of existing resources.

The team recommends that short-term technical assistance (TA) for an external facilitator be sought to help the Board finalize a reasonable strategic plan with realistic performance targets and resource requirements. However, before that is possible, the Board must first turn its attention to stabilizing FLEP's institutional identity.

9.1.2 Organizational Status

As noted in Chapter 1, FLEP has been pursuing official, legal registration as a Ugandan NGO since 1994. The evaluation team wholeheartedly supports this decision. NGO status would place FLEP in a better position to marshal external resources and serve as an independent contractor, with obvious potential financial benefits. Operationally, it would make FLEP transactions more transparent. In the past, vehicles and other capital acquisitions could not be registered in the

name of FLEP in accordance with standard grantee awards, simply because FLEP did not have the necessary legal status.

The team was advised that the Board has drafted a charter for the new NGO and submitted it for approval to the Busoga Diocesan Council (FLEP is a church organization). Once this approval has been received and the Board has voted final ratification, the final step will be to submit application for NGO status for the approval and signature of the Prime Minister of Uganda.

While the desire and justification for this move are clear, other factors have intervened to slow down the process. Attendance at Board meetings has been poor. The focus on recently concluded national elections and the fact that some members of the Board were political candidates were significant impediments to Board activity. Another potentially more serious obstacle is an ongoing conflict over church policy and leadership between different factions of the hierarchy of the Busoga Diocese. While FLEP is not directly involved, the Bishop who has been instrumental in FLEP's success is, and there is concern that the surrounding controversy will delay or even derail the process of obtaining diocesan approval of FLEP's draft NGO charter.

The team feels strongly that the entire NGO registration process needs to be re-energized, otherwise the process risks being mired indefinitely in uncertainty and compounding morale and management problems within the organization. As principle funder, Pathfinder has the necessary leverage to urge the FLEP Board to work with the Diocese to obtain charter approval and then make certain that the Board?s ratification and application to the Prime Minister's office go forward with the least possible delay. A goal of final approval of FLEP's NGO status by the end of 1996 does not seem unreasonable. Once it is achieved, Board members should then redouble their efforts to finalize and operationalize a realistic strategic plan.

9.1.3 Management Issues

FLEP management has been in a state of flux. In late 1995, the long-time (and highly respected) FLEP project manager moved to Pathfinder/Kampala to become the DISH CBD coordinator. Her assistant was made acting project manager while the Board launched a search for a permanent replacement. That process has been bogged down, again because the Board has been distracted by other matters, not all FLEP-related.

Low morale caused by uncertainty over organizational leadership has been exacerbated by uneasiness over the looming diocesan controversy and budget problems. The impact of the cut-off in VHW allowances has been described elsewhere in this report. Other cutbacks have led to indefinite delays in filling important positions, such as program analyst, which has been vacant for almost two years (see Section 8.2). In addition, the former project manager, who still lives in Jinja (where the FLEP office is located), has been much in evidence in her old office. Her intent has been to be helpful, but her forceful presence has caused confusion among staff members as to

who is actually in charge.

Again, the Board of Trustees should be urged to resolve the project manager situation forthwith, either by following through on a vigorous search or formally appointing the acting project manager to the position. (Although perhaps less forceful in style than her predecessor, the team found her highly committed to FLEP's mission, and she possesses excellent technical qualifications and interpersonal skills.) Finally, whichever decision is made, the former manager should be gently urged to devote her full time to DISH, both because it needs her and because it will enable the new project manager to establish her or his own leadership style.

Notwithstanding restrictions on funds, the team also urges FLEP to fill the vacant program analyst position. Having an analyst on staff might not have avoided the analytical and statistical problems with the 1995 end-of-project evaluation described in Section 7.3; it might have enabled them, however, to be flagged and dealt with earlier. As noted, FLEP has considered modifying the analyst position to include both information management and resource mobilization. The evaluation team is not opposed to such a plan if a sufficiently qualified person can be found quickly.

9.1.4 FLEP-Government Interface

From discussions with DMOs in all three FLEP districts (Jinja, Iganga, and Kamuli), the team learned that FLEP has been diligent in its efforts at coordination and collaboration with the government health structure. It was praised, among other things, for its success in bringing services to underserved areas, the high quality of its services and training programs, and the regularity of its reporting.

At the same time, the team heard criticism from some sectors over a perceived lack of effective joint planning, duplication of services, and other issues. Although the team was not always able to verify the accuracy of these complaints, it did feel that more could be done to enhance synergy with government health entities. Some suggestions, which could work to the advantage of both decentralized public sector health structures and FLEP's long-term viability, include the following:

(1) FLEP should be more proactive in information sharing and joint planning between its clinics, the DMO, and Local Councils. Areas of common interest include location and construction of health units, equipping and staffing of clinics, fee setting, joint training, and bulk purchasing of commodities.

(2) FLEP should explore more formalized cooperative arrangements between DMOs/Local Councils and FLEP clinics. Given expected resource constraints, clinics could be funded jointly and operated by FLEP, as an NGO, and the Councils. A **Memorandum of**

Agreement could define responsibilities of FLEP and local governments, sites to be "jointly funded and operated," the status of clinic staff, and reporting requirements.

(3) The Memorandum of Agreement should also tackle issues impinging on the current running of FLEP clinics, specifically (a) the counter-productive practice of locating public FP/AIDS/STI clinics in proximity to the FLEP network (to the detriment of broader access) and (b) recruitment of FLEP practitioners to better-salaried positions at public facilities.

(4) The FLEP Board and staff should lobby for the use of a portion of MOH hospitals' cost sharing revenues for preventive/promotive health services such as those provided by FLEP clinics.

(5) MOH support to FLEP in terms of contraceptive commodity supplies, drug kits, and training should continue.

All agree that FLEP provides a critical complement to MOH services in Busoga Diocese. Once its NGO status is finalized, it should redouble its efforts to make the skills and services it has developed of use, not only in Busoga but throughout the country through DISH. In addition to realizing financial benefits from the provision of training and other services, FLEP will then have reached full flower as an indigenous provider of technical and management assistance.

9.2 EAD and FLEP: Overall Management Issues

As noted on several occasions in this report, while the evaluation team sees ample justification for supporting FLEP's attempt to achieve NGO status and thus strengthen its special role as both participant in and technical resource for DISH, it hopes that EAD can be fully absorbed into DISH as soon as possible. EAD has made a good start at improving access to primary care services in a very underserved region, but it needs the resources that DISH (and indeed FLEP, as a technical advisor to DISH) can provide in terms of training, vehicular and commodity support, and in-depth experience with integrated services.

EAD also has a poorer record than FLEP in terms of collaboration with the DMOs in the region. It was criticized for what was perceived as an arms-length treatment of government programs and policy-makers, in the sense that EAD shares information and reports but has (in the view specifically of the Mbarara DMO) made little effort to engage in any collaborative planning process. A case in point was the lack of any sort of "map" which would show where EAD and government service points are located in East Ankole and thus make possible an equitable distribution of scarce resources.

Again, closer involvement by DISH, and in particular by its CBD coordinator, in EAD will bring

needed experience and expertise to bear in alleviating these problems. To make this a reality, one point that should be made clear to all concerned is that responsibility for management and technical oversight of the FLEP and EAD projects rests fully with Pathfinder/Kampala.

Discussions by the evaluation team with the Pathfinder regional staff, the DISH chief of party and staff, and project personnel made it clear that, while this oversight responsibility may be clear on paper (in job descriptions, etc.), it is still an area of some ambiguity in actual function. Original oversight of the two projects by Pathfinder/Nairobi was a legacy of the fact that they were (and still are) supported by central USAID/Washington funds and began well before the DISH CA was signed between Pathfinder and USAID/Uganda. FLEP and EAD are now parts of DISH, and, in the interest of programmatic coherence, should be answerable to DISH management.

Some anomalies persist, however; for example, the EAD project manager still sends his quarterly reports to Nairobi. (If, because project funds do in fact come from there, the Nairobi office needs to receive financial reports, could they not be submitted through the Kampala office?) When asked, he said he considered Nairobi his primary supervisor, an attitude which makes the DISH CBD coordinator feel constrained in terms of her authority to make management or technical decisions regarding EAD? inputs which are sorely needed to strengthen the project.

Simply clarifying the lines of program and management authority over FLEP and EAD within the DISH framework for all concerned should remove lingering impediments to full management coherence. Pathfinder/Nairobi will of course retain its advisory role in connection with the two projects, as with DISH as a whole and its other projects in the region.

9.3 Recommendations

27. The process of obtaining official NGO status for FLEP should be energized, with Pathfinder exercising whatever leverage it can with the FLEP Board of Trustees, toward the goal of FLEP becoming a legally approved Ugandan NGO before the end of 1996.

28. The FLEP Board of Trustees should move quickly to fill the positions of FLEP project manager (the evaluation team feels that the acting manager is a very acceptable candidate) and program analyst (combined with resource development if an acceptable candidate can be found).

29. The Board of Trustees should obtain the technical assistance necessary to review in detail, finalize, and promulgate a strategic plan for the organization which combines realistic program plans with resource development strategies.

30. Increased attention should be paid to enhancing synergy between FLEP/EAD and DMOs

and other public sector health entities. Ideas suggested in the text could provide a point of departure.

31. It should be made clear that full responsibility for technical and management oversight of FLEP and EAD rests with Pathfinder/Kampala. Pathfinder/Nairobi should play an advisory role as it does with its other projects.

10. FLEP FINANCIAL SUSTAINABILITY

10.1 Introduction

As requested in the SOW, this section assesses the financial and institutional sustainability of FLEP activities with reference made to sustainability issues covered in other sections of this report. FLEP has successfully attracted diverse sources of financial and in-kind support, both foreign and local, to an extent unprecedented in rural Uganda. Such large and diverse subsidies are difficult to sustain, however. FLEP's ability to restructure its support relationships is key to its institutional survival.

10.2 Cost Recovery Programs

FLEP health units have three types of fee-based cost recovery schemes: one for contraceptives, a second for curative care/drugs, and a revolving fund for STI drugs.

10.2.1 Cost Recovery from Contraceptive Services

Since 1986, FLEP has distributed contraceptives and provided FP services on a modest fee basis. Fees range from the equivalent of US$0.01 for one foaming tablet to US$2.50 for NORPLANT®, tubal ligation, and vasectomy. Since 1994, pills and condoms have been supplied under the SOMARC social marketing program. VHWs return proceeds from their sales to their respective health units.

Revenues collected at each clinic and forwarded to FLEP headquarters comprise the so-called "generated income." Use of the revenues is determined by the FLEP project manager. The closing balance of this fund was USh 2.9 million (US$2,900) as of the end of the project's 14th Quarter, March 1996 (see Table 8). Most of the contraceptive cost sharing revenues are used for clinic supplies; some are used as staff stipends.

According to the project accountant, the spike in revenue collections in the 8th and succeeding quarters, as shown in Table 8, may be due to increased clinic load following an intensive IEC campaign. The spike in expenditures starting in the 9th quarter was due to payment of delayed staff stipends.

Table 8

Receipts and Expenditures from Contraceptive Cost Sharing Program by Project Quarter (UShs)

Quarter*	Receipts	Expenditures	Deposits and Cash
Q1 - ND92J93	263,988	118,000	n.a.
Q2 - FMA93	231,260	2,900	n.a.
Q3 - MJJ93	531,260	272,850	n.a.
Q4 - ASO93	296,200	654,050	n.a.
Q5 - ND93J94	200,850	394,550	n.a.
Q6 - FMA94	211,450	214,700	n.a.
Q7 - MJ94	637,378	840,060	n.a.
Q8 - JAS94	2,387,100	509,950	n.a.
Q9 - OND94	1,472,545	1,543,007	1,440,918
Q10 - JFM95	5,410,567	4,213,000	2,638,485
Q11 - AMJ95	1,885,850	3,826,900	697,435
Q12 - JAS95	n.a.	n.a.	n.a.
Q13 - OND95	1,866,900	425,000	1,453,501
Q14 - JFM96	899,750	0	2,876,735

Source: Project Quarterly Reports, FLEP Accounting Office.

*Months abbreviated by first letter.

10.2.2 Cost Recovery from Curative Services/Drugs

These revenues are collected at clinics for maternity care, deliveries, other simple curative services, and drugs. At present, only 25 percent of FLEP clinics have maternity services. Modest fees are also collected for preventive care. For instance, an immunization card costs USh 10.

Because these funds are considered community resources, and many transactions are in-kind, there are no records of them at FLEP headquarters. However, interviews indicate that monthly clinic revenues vary widely, depending on their volume of patients, as follows:

High volume:	USh 100,000 (US$100)
Medium volume:	USh 80,000 (US$80)
Low volume:	USh 30,000-50,000 (US$30-50)

Ordinarily, revenues are used to purchase drugs, clinic supplies, and nonmedical items (charcoal, soap, or paint) and are used for clinic staff incentives. Revenues have historically not been used for VHW stipends. Clinic upkeep and repair/construction materials ordinarily come from community donations rather than cost sharing revenues.

10.2.3 STI Drug Revolving Fund

The project converted a recent Japanese grant of US$47,000 into a revolving drug fund. FLEP procures STI drugs and distributes them to clinics through their respective zonal depots. All 48 clinics in the eight FLEP zones are participating and are well-supplied for the next few years. Clinics are given an initial supply of drugs which are then dispensed under a "full-cost" recovery system with modest markup. Fee collections are used to replenish STI drug supplies.

The revolving fund is at an early stage. FLEP has developed the implementing guidelines (dated April 1995) and has conducted supervisors' training on their use. However, clinic practitioners and FLEP headquarters staff members are not yet fully capacitated to manage the revolving fund. It is not clear who sets the fees and on what basis, and reporting systems for fee revenues are not yet in place.

10.3 Assessment of Cost Recovery Efforts

While the contraceptive cost recovery program has good records and generated income is reported regularly, the curative services/drugs program suffers from poor record keeping. Also, the pervasiveness of in-kind payments for clinic transactions makes it virtually impossible to accurately assess the level of resources generated. Aware of these shortcomings, we nonetheless estimate revenues as follows:

- Contraceptive cost recovery: Based on data presented in Table 8, the program generated an average of USh 773,484 (US$773) per month from July 1994 to March 1996.

- Cost sharing program for curative care/drugs: Assuming that the 48 FLEP clinics are equally divided between high-volume, medium-volume, and low-volume services (16 of each), with corresponding monthly revenues of USh 100,000, USh 80,000, and USh 30,000, all clinics together should be able to generate USh 3.36 million (US$3,360) a month.

Summing up, FLEP health units mobilize around US$4,133 per month in cost recovery fees of all kinds. This figure translates to US$49,596 (roughly US$50,000) annually. Given estimated annual project expenditures of around US$300,000, cost recovery under the Pathfinder grant could be as high as 17 percent.

It must be emphasized that this cost percentage is at best a "guesstimate." No accurate data are available for total revenues generated, as not all health unit collections are reported to FLEP and many transactions are in-kind.

With respect to the STI drug revolving fund, no hard data are available at present. It is only known that the revolving fund was "capitalized" with a US$47,000 grant over five years. For simplicity, one can assume an annual "capital" of US$9,400. Assuming a five percent markup on the sale of these drugs, the fund should be able to generate revenues of about US$822 a month.

10.4 Services Amenable to Greater Cost Recovery

Schemes to increase cost recovery from fees must be evaluated against the need to preserve the public health benefits from FLEP-provided services. There are some services, however, which might be amenable to modest fee increases:

- *Voluntary surgical contraception:* The demand for both TL and vasectomy in Busoga is steadily increasing, but costs currently far exceed user fees. Recent estimates put the cost of a VSC procedure at USh 49,358, against a fee of USh 2,500, representing a cost recovery rate of only five percent. The possibility of gradually increasing VSC fees to recover from 10 percent to 30 percent of costs should be considered, although this may be an unrealistic burden on clients who have difficulty even paying for transportation to service points.

- *STI drugs:* FLEP providers should ensure that the required five percent markup is adhered to. Training, management information support, and supervision should be provided to be sure that the capitalization of the drug revolving fund is not eroded.

- *STI lab services:* FLEP plans to establish an STI laboratory, staffed by two technicians and attached to its Jinja clinic. This should be operated on an income-generating basis.

- *Deliveries:* A small charge for deliveries should be considered. Free or almost-free delivery services provides adverse incentives for FLEP's FP initiatives.

? *Postabortion care:* Pathfinder has a private grant to test using nurses and midwives to manage postabortion cases. If this proves feasible, fees should be charged for such services.

As it recommends that these and other services be examined for their potential to generate income for FLEP, the evaluation team is aware that one of its principle recommendations, reinstatement of allowances for VHWs, will mean an added financial burden. It feels strongly, however, about the importance of maintaining a low-cost service model of demonstrable impact for a long enough period to properly test it against others in Uganda and elsewhere in Africa. It is not inconceivable that the FLEP model will ultimately prove the most rational approach to sustaining community-based services.

10.5 Public Sector Support

10.5.1 Current Inputs

The Ministry of Health, through the DMOs, provides FP equipment and supplies, contraceptives, and printed IEC materials to FLEP clinics. DMOs also train some FLEP staff members and shoulder part of the costs of transporting clients to FLEP clinics in Jinja and Kamuli for permanent contraceptive methods. In 1993, this support amounted to USh 2.2 million (US$2,200) according to an April 1995 audit.

Since the Ugandan government's decentralization of health services below the hospital level, local governments (at district, county, and subcounty levels) have been given a 50 percent share of local tax revenues and corresponding responsibility in the delivery of social services, including health. While FLEP has not fully exploited the potential for public-private sector collaboration in health, modest collaboration efforts have been undertaken since 1993, which indicates a potential for more. FLEP has benefited from various cash and in-kind grants from Local Councils. The DMOs have also provided vaccines, training, and supervisory support to FLEP clinics.

10.5.2 Potential for Expanded Collaboration

Two mechanisms for expanded collaboration between FLEP and the MOH/DMOs would appear to have potential for enhancing project sustainability:

? *Direct grants from district governments:* Under the government of Uganda's decentralized health system, districts and Local Councils can disburse funds to NGOs and missions that qualify as health service providers or are designated as clinics or hospitals. In fact, according to key informants, eight FLEP clinics are already receiving support from DMOs but on an irregular basis. It appears that the full potential of collaboration between DMOs and FLEP remains to be exploited.

Clearly, it is less costly for a DMO to support a well-established FLEP clinic than to put up a parallel facility nearby. The DMO for Kamuli, for example, is keen on providing district support to FLEP to enhance the coverage and quality of its services, which he acknowledges are already high. In turn he would like to see a much higher level of information sharing and joint planning than is now (in his view) the case. This would lead, for example, to clearer understanding of the dimensions of catchment areas and the optimum location of service points. Some of his requests (such as the chance to give input into FLEP's use of its own grant funds) were unreasonable. However, there is clearly room for FLEP to further develop its collaborative relationships with DMOs, which in turn could lead to increased financial support (see Section 9.1.4).

? *Subsidies from hospital cost recovery program:* The MOH is currently pilot testing its cost recovery program for curative services, formulating policies, and developing operational manuals to carry out this initiative. Revenues from curative services are an appropriate source of support for the preventive services that FLEP provides. However, at present all revenues are retained at each hospital, mainly for staff incentives.

Uganda's cost recovery program could be modified so that a proportion of its revenues are devoted to preventive care. Under a similar program in Kenya, for instance, 25 percent of hospital revenues are devoted to funding promotive and preventive health services. Revenues are programmed by the district health authorities for a variety of public health interventions including FP, MCH, nutrition education, and environmental control. It is recommended that this model be tested in Uganda and a fixed proportion of the proceeds be earmarked for activities like those FLEP provides.

10.6 Other Avenues to Sustainability

10.6.1 External Sources

Pathfinder, using USAID funds, has been FLEP's largest supporter by far. Its present grant, the third in the project's life, now totals US$1.2 million. Smaller amounts have come from Pathfinder's private sources (not least for construction of FLEP's impressive headquarters building and clinic in Jinja), the World Bank, the Japanese government, and other international sources. Donor funds are becoming less available, however, and for this reason the FLEP Board and its management must look for ever more creative and sustainable means of diversifying its funding base and reducing its dependence on outside sources.

10.6.2 Endowment Fund

The FLEP Board has expressed strong interest in exploring the possibility of setting up a FLEP endowment fund, the earnings from which could go to covering recurrent and/or capital costs. The organization has distinct advantages in its consideration of an endowment. It has an excellent reputation, a long-range vision (lacking only the details, which will be developed in its strategic plan), and proven access to donors. While increasingly dubious about long-term commitments, donors are often attracted to one-time gift opportunities with the sort of growth potential that an endowment fund provides.

The evaluation team strongly encourages the FLEP Board to pursue this avenue, understanding that it will take a long time and much spade work to bring it to reality. It also urges Pathfinder and USAID to provide the technical assistance needed by FLEP to work on the requirements and processes for this major initiative, noting that this is yet another reason for moving the NGO registration process ahead as quickly as possible.

10.6.3 Corporate/Private Sponsorship

Corporate sponsorship is another avenue that should be explored. Jinja, where FLEP is centered, is Uganda's industrial capital. There is great potential for industrial and commercial firms to support elements of FLEP's diverse activities, such as IEC (publications, radio spots, village dramas), medical outreach, AIDS counseling, or VHW stipend support. Private philanthropy among business groups (Lions, Rotary, Asian business community) also should be explored.

10.6.4 The Church

While the evaluation team was not assigned the task of assessing the capacity of the Church of Uganda to provide financial support to FLEP, the strategic planning exercise should explore this possibility. The Diocese of Busoga, if not the church as a whole, might, for example, be interested in becoming a supporter of the FLEP endowment. Such a decision might be made easier after FLEP's NGO status has been secured.

The evaluation team was particularly struck by the scope and variety of investments that have been made in church projects and services in Mbarara, where the Bishopric presides over a diverse and impressive range of preventive and curative health services and facilities, as well as schools and other services. This is noted to draw attention to the unique power of the church to attract support for worthy causes. Given its strong links with the Church of Uganda, FLEP should not fail to explore this source of possible future assistance for selected activities.

10.7 Conclusion

Although Uganda is on the rebound economically, the country, especially the health sector, continues to suffer from extreme resource constraints. Thus there should not be false expectations as to the sustainability of FLEP even if and as recommendations suggested above are put in place. They will surely improve prospects for sustainability, not necessarily ensure them.

10.8 Recommendations

32. All viable opportunities for cost savings and cost recovery should be explored by FLEP management, including opportunities to benefit from MOH/DMO resources through closer collaborative relationships.

33. As prospects for continued external support diminish, particular emphasis should be given, with technical assistance provided as needed, to developing the idea of a FLEP endowment fund and generating corporate and other private Ugandan support for FLEP activities.

APPENDIX B

BIBLIOGRAPHY

AMREF Child Survival Project. "Is a Community-Based Approach Effective in Meeting Child Survival Goals? Baseline and Post-Intervention Results in Two Sub-Counties of Uganda." AMREF/Kampala, July 1995, p.1,15.

AMREF/DANIDA. "The Impact of CBHC in Najja Sub-County,Mukono District." AMREF/DANIDA, Mukono District Health Services Project, Kampala, Aug. 1995.

Asiimwe-Okiror, G. "Brief Report on Population-Based Survey in Jinja District." STD/AIDS Control Programme, Nov. 1995.

Becker, J. "Challenges in Integrating HIV/STD Prevention and Family Planning." Presentation to Third USAID AIDS Prevention Conference, August l995.

Bertrand, J.T., R.J. Magnani, and J.C. Knowles. Handbook of Indicators for Family Planning Program Evaluation. Carolina Population Center, Chapel Hill, NC, l994.

Bruce, J. "Fundamental Elements of Quality of Care: A Simple Framework," Studies in Family Planning, 21(2), 61-90. l990.

Castrillo, M. "Lessons Learned from the Situational Analysis Study in Five Health Districts of La Paz and Cochabamba, Bolivia." MotherCare II Project, Washington, D.C., l995.

Crippen, Cheryl. "Knowledge, Attitudes, and Practices of Family Planning, HIV/AIDS, Sexually Transmitted Diseases, and Maternal Health in Uganda: A Literature Review." DISH Project, Kampala, Uganda, Dec. 1994.

Enkin, M., Marc J.N.C. Keirse, M. Renfrew, and J. Neilson. A Guide to Effective Care in Pregnancy & Childbirth. Oxford University Press, Oxford, 1995.

Fortmann, L. Peasants, Officials, and Participation in Rural Tanzania: Experience with Villagization and Decentralization. Cornell University Press, Ithaca, NY, 1980.

Green, E.C. Indigenous Healers and the African State: Policy Issues Concerning African Indigenous Healers. PACT Press, New York, (forthcoming, fall 1996).

Heggenhougen, K., P. Vaughan, Eustace P.Y. Muhondwa, J. Rutabanzibwa-Ngaiza. Community Health Workers, The Tanzanian Experience. Oxford University Press, Oxford, 1987.

Iyun, F. "An Assessment of a Rural Health Programme on Child and Maternal Care: The Ogbomoso Community Health Care Programme," Social Science and Medicine, 29(8):933-8, 1989.

Jancloes, M. "Could Villages Do Better Without Their Volunteer Health Workers?" World Health Forum, 5(4):296-300, 1984.

Kaijuka, Emmanuel M., Edward Z.A. Kaija, Anne R. Cross, and Edilberto Loaiza. Uganda Demographic and Health Survey 1988/1989. Ministry of Health and Institute for Resource Development/Macro International, Inc., Entebbe, Uganda, October 1989.

Karungari, K. et al. "Family Planning Needs in Uganda: Key findings from a baseline survey of selected urban and peri-urban areas." FPAU, Kampala, Uganda; and Johns Hopkins University, Baltimore, MD; Feb. 1993.

Kisubi, W.K. "An Evaluation of the Pathfinder Funded FP Program." Family Life Education Project, Busoga Diocese, Jinja, Uganda, January 1991.

Kisubi, W.K., W. Pressman, J. Mukaire, and J. Kintu. "An Internal Evaluation Report." Family Life Education Project, Busoga Diocese, Jinja, Uganda, September 1988.

Klein, S., with S. Miller (medical editor). A Book for Midwives. Hesperian Foundation, Palo Alto, CA, l995.

Kwast, B., S. Miller, C. Conroy. Management of Life Threatening Obstetrical Emergencies. MotherCare, Washington, D.C., 1993.

Marshall, M. and S.T. Buffington. Life-Saving Skills Manual for Midwives. American College of Nurse-Midwives, Washington, D.C., 1991.

Mathews C., H. van der Walt, P. Barron. "A Shotgun Marriage--Community health workers and government health services. Qualitative evaluation of a community health worker project in Khayelitsha." South African Medical Journal, 84(10) p. 659-63, Oct 1994.

Matomora, M.K. "Mass Produced Village Health Workers and the Promise of Primary Health Care," Social Science and Medicine, 28(10): 1081-4, 1989.

Mburu, F.M., "Whither Community Health Workers in the Age of Structural Adjustment?" Social Science and Medicine, 39(7), 883-5, 1994.

Menon, A. "Utilization of Village Health Workers within a Primary Health Care Programme in

The Gambia." Journal of Tropical Medicine and Hygiene, 94(4):268-71, Aug. 1991.

Miller, S. and P. Kelly. "Questionnaires and Checklists for the Pakistan NGO Initiative Rapid Health Facilities Assessment." MotherCare and Basics Projects, Arlington, VA, l996.

Ministry of Finance and Economic Planning and Macro International, Inc. Uganda Demographic and Health Survey 1995. Macro International, Inc., Kampala, Uganda, November 1995.

Ministry of Health. "The Health Management Information System Training Package, Volume 1: The Health Unit Level," The Republic of Uganda, Entebbe, Uganda, July 1996. (Draft)

Potts, Malcolm. "The Urgent Need for a Vaginal Microbicide in the Prevention of HIV Transmission," AJPH, 84(6):890-1, June 1994.

PRICOR. "Niger: Stimulating Community Participation in the Village Health Worker Program," Center for Human Services, Primary Health Care Operations Research Project (PRICOR), Besthesda, Maryland, Nov. 1990.

Public Health Service, National Institutes of Health. "Caring for Our Future: The Content of Prenatal Care (A report of the Public Health Service Expert Panel on the content of prenatal care)." U.S. Department of Health and Human Services, Washington, D.C., 1989.

Rosenberg, Michael, A. Davidson, J. Chen, F. Judson, and J. Douglas. "Barrier Contraceptives and Sexually Transmitted Disease in Women: A Comparison of Female-Dependent Mothers and Condoms," AJPH, Vol. 82, No. 5, p. 669-674, May 1992.

Shumba, P.S.S. Evaluation Module: Regional Quality of Care Workshop, Nairobi, Kenya, l996.

Shumba, Paul S.S. "Family Life Education Project End of Project Evaluation Report (NCA/UGA:001-3), Pathfinder International, Africa Region, July 1995.

Sloan, N.L., C. Quimby, B. Winikoff, N. Schwalbe. Guidelines and Instruments for a Situation Analysis of Obstetric Services. The Population Council, New York, 1995.

Von Freyhold, M. Ujamaa Villages in Tanzania: Analysis of a Social Experiment. Monthly Review Press, New York, 1979.

Walt, G., D. Ross, L. Gilson, L. Owuor-Omondi, T. Knudsen. "Community Health Workers in National Programmes: The case of the family welfare educators of Botswana," Transactions of the Royal Society of Tropical Medicine and Hygiene, 83(1):49-55, Jan-Feb 1989.

Weir, S., P.J. Feldblum, L. Zekeng, and R. Roddy. "The Use of Nonoxynol-9 for Protection against Cervical Gonorrhea," AJPH, 84(6):910-914, June 1994.

WHO. "Essential Elements of OB Care at the First Referral Level, Annex 2-5,"
World Health Organization, Geneva, 1993.

APPENDIX C

LIST OF PERSONS CONTACTED

Pathfinder International

Dr. Elizabeth Lule	Regional Representative
Dr. Wilson Kisubi	Assistant Regional Representative
Mr. Jean Karambizi	Chief of Party, DISH Project
Ms. Joy Mukaire	CBD Manager, DISH Project
Mr. Bongs Lainjo	Logistics and Information Systems Advisor, DISH Project
Mr. Paul Shumba	Regional Technical Advisor for Evaluation

USAID/Uganda

Mr. Jay Anderson	Health, Population and Nutrition Officer
Dr. Cecily Banura	Health Specialist
Ms. Betty Nabirumbi	Program Assistant

Makerere University

Dr. James P. M. Ntozi	Director, Institute of Statistics and Applied Economics
Dr. John Ssekamate-Ssebuliba	Director, Population Studies Center

Population Secretariat

Dr. Emmanuel Sekatawa	Demographic Consultant

Ministry of Health

Dr. Katumba	MOH, Entebbe
Mr. Vincent Ndaziwa	Analyst, Health Planning Unit
Ms. Linda Archer	Consultant, Danish Red Cross
Mr. Dirk Van Damme	Consultant, WHO

SOMARC Project

Ms. Sara Tifft	Country Manager

AMREF

Dr. Dean Shuey	Country Director
Ms. Joyce Kintu	Training Officer

Family Life Education Project

Bishop Cyprian Bamwoze	Project Director
Ms. Florence Kalikwani	Project Manager
Dr. Tom Tuma	Former FLEP Project Manager
Mr. George Batwawula	Finance Officer
Mr. Zebedee Tayoleke	Community Development Officer
Mr. George Kimalyo	VHW Supervisor, Kamuli
Mr. Sam Mugoya	VHW Supervisor, Iganga
Ms. C.T. Mulumba	VHW Supervisor, Kamuli
Ms. J. Baitanunga	VHW Supervisor, Jinja
Ms. Monic Mubiru	VHW Supervisor, Jinja
Ms. Perwa Mulumba	VHW Supervisor, Kamuli
Mr. John Mukembo	Trainer/Supervisor
Ms. Freda Balehe	Trainer/Supervisor
Mr. Sebastian Balinaine	Trainer/Supervisor
Ms. Grace Isabirye	Trainer/Supervisor
Mr. Briham Muzige	Trainer/Supervisor
Ms. Margaret Naisambi	Trainer/Supervisor
Ms. Ruth Widhuba	Survey Coordinator
Dr. David Kazangu	FLEP Board Member/MSRDP Coordinator
Dr. Frank Nabwiso	FLEP Board Member/Consultant

Iganga District

Dr. Baguma	District Medical Officer
Ms. Margaret Rose Tembe	Enrolled Midwife, Mawunde
Ms. Frances Lugose	Midwife/AH Visitor, Bukoteka
Mr. Paul Nigambi	Health Committee Treasurer, Mawunde
Ms. Jane Ndizawa	Nurse-Midwife
Sheik Muhammed Kamira	Chairman, Health Unit Committee
Mr. Patrick Tibenkana	Nurse/Medical Assistant, Nasuuti
Ms. Ida Basailrwa	VHW Supervisor
Mr. David Baise	Chairman, Health Committee, Nasuuti
Ms. Jane Frances Abilla	Assistant Midwife

Ms. Ruth Muganga — Enrolled Midwife, Bufula
Ms. Perwa Mulumba — VHW Supervisor
Numerous Village Health Workers, nurses' aides and other personnel

Jinja District

Dr. Frank Nabwiso — FLEP Board Member/Consultant
Dr. David Kitimbo — District Medical Officer
Ms. Irene Kanobe — Registered Nurse Midwife
Ms. Margaret Baliraine — Practitioner, Mawanyago
Rev. Martin Grace Bwanga — Vicar, Mawanyago Parish
Mr. James Namwano — Chairman, Mawanyago Local Council
Mr. Moses Iruba — Vice-Chairman, Mawanyago Local Council
Mr. F.E. Balyejusa — Teacher, Buyemba Primary School
Ms. Gertrude Mbirire — Nurse-Midwife, Muguluka

Numerous Village Health Workers, Nurses' Aides and other personnel in Mawanyago, Muguluka and Masese

Kamuli District

Dr. Mukoyo — District Medical Officer
Ms. Christine Nazziwa — District Health Visitor
Ms. Victoria Osire — Nurse
Ms. Lyawaghala-Kafuko — Nurse
Ms. Gertrude Babita — Nurse-Midwife, Kamuli VSC Unit
Mr. Wakaisuka — FLEP Board Member/Kamuli Teachers College

<u>East Ankole Diocese, Family Planning Services Project</u>

Bishop Betungura — Project Director
Rev. Philemon Tinua — Diocesean Secretary
Rev. John Muhanguzi — Project Manager
Mr. Jotham Kambagina — Deputy Manager/Program Analyst
Ms. Margaret Bushaya — CBD Supervisor
Ms. Stella Rwabitetera — Nurse-Midwife
Ms. Jessica Mwesigwa — Nurse-Midwife
Ms. Naomi Mugizi — Nurse Aide
Mr. Emmanuel Mbarebaki — Administrative Assistant/Accountant
Ms. Florence Kanakulya — Storekeeper/CBD
Ms. Christine Nyausheuo — Secretary/Cashier

Mbarara District

Dr. P. Byaruhanga	District Medical Officer
Ms. Katusiime Vanice	Senior Nursing Officer
Dr. Nuaerwa Benon	NUST, Sessional Doctor and Surgeon

Ntungamo District

Ms. Maume Mugizi	Nurse Aide
Mr. Harvard Tarmwa	Village Health Worker
Mr. Robert Mugume	Village Health Worker
Mr. Roy Mukube	Community Based Distributor, Nyakyera
Ms. Jolly Tumusiime	Community Based Distributor, Nyakyera
Ms. Loyce Mugume	Community Based Distributor, Nyakyera

APPENDIX D

QUALITY OF CARE ASSESSMENT METHOD

Forms designed for this evaluation were modified from the MotherCare Situational Analysis Modules (Castrillo, l995), the World Health Organization Safe Motherhood Needs Assessment Questionnaires (WHO, 1993), the Population Council's obstetric services situation analysis guidelines (Sloan et. al., l995), the MotherCare/BASICS Guides (Miller and Kelly, l996), the FLEP Supervisors' Checklists for monitoring and self-evaluation, and the draft "Quality Assurance Checklists" from the Pathfinder Regional Quality of Care Workshop (Shumba, l996). Because one of the goals of this evaluation was to determine if and to what extent MCH, FP, STI diagnosis and treatment, and HIV/AIDS education and counseling had been integrated, formerly separate questionnaires were combined so that client/provider observations and client exit interviews could be oriented toward the delivery of integrated RHS. The following tools were used to guide this analysis:

Structured Observation Checklists:

1. Facility Equipment and Supplies Checklist (FC)
2. Integrated RHS Delivery Observation (OB)

Questionnaires:

1. Service Provider Interview (SPI)
2. Integrated RHS Client Exit Interview/Client Survey (EI, CS)
3. Supervisors/Trainers Focus Group Interview Guideline (FG)

Training and Supervision:

1. Training Curriculum Review (TR)
2. Training Session Observation (TO)
3. Supervision Checklist Review (SR)

Structured visits make it possible to observe and assess client/provider interaction and the quality of providers' counseling and clinical skills. (In facilities where client/provider interactions were not observed, the providers' knowledge and skills were tested by role plays and creating scenarios which required providers to describe and act out procedures.) Service provider interviews are designed to assess aspects of providers' training, supervision, and knowledge. The facility equipment and supply checklist assesses inventory, stock-outs, decontamination procedures, logistics, and record keeping. The interviews with clients are designed to assess the understanding and interpretation of quality of care from the clients? perspective. The evaluators

also conducted a focus group of FLEP trainer/supervisors (now called zonal managers), who are also providers.

In addition to using these methodologies, training materials and curricula and providers' checklists and guidelines (for monitoring services, health units, and VHW activities) were reviewed. Evaluators reviewed the "Quarterly Supervisors' Reports" from l994 to March 1996, the "Supervisors' Quarterly Work Plans" from the same period, and the completed "Review of Supervisors' Checklists" from l994-l995. They also attended a training session on STIs from the DISH Project "Comprehensive RHS Training Workshop" in Mbarara.

Twenty-nine indicators from the Bruce Framework on Quality of Care (Bruce, l990) and the "Quality Indicators for Clinic-Based Family Planning Programs" (Bertrand, Magnani, Knowles, l994, p. 209-214) were adapted for assessing quality of care in integrated RHS programs. Various combinations of the tools listed above were used to gather information on these indicators in the course of field visits in Busoga and East Ankole Dioceses. Results are listed in the following appendices.

APPENDIX E

FLEP QUALITY OF CARE INDICATORS SCORES

Indicator	Score
Interpersonal Relationships	
1. Service providers* are trained in interpersonal relations	always
2. Service providers use IPC skills/GATHER/YOMOMO	often**
3. Clients report feeling welcomed and at ease	always
4. Number/range of methods available	always
5. Provider offers all appropriate methods	always
Information Given to Client	
6. Provider demonstrates appropriate counseling skills	always
7. Provider has checklist available on information to cover during counseling session	often
8. Provider gives accurate, unbiased overview of all methods	often
9. Provider gives accurate information on accepted methods	often
10. Informational materials are available on all methods	always
11. Privacy is acceptable for counseling and exam	often
12. Consent form is available and signed by client	always
Technical Competence/Training	
13. Written guidelines on FP/STI/HIV/Maternity/ Immunizations are available	often
14. Clinical providers receive relevant training for tasks	often
15. Staff members receive periodic refresher/in-service trainings	often
16. Basic items are present for health care delivery	often
17. Provider can accurately explain FP methods, immunization schedules, STI/HIV prevention	always
18. Provider demonstrates skill in clinical RHS procedures (bimanual exam, speculum exam, physical assessment skills, delivery skills)	always
19. Provider demonstrates knowledge of contraindications to FP methods	always
20. Provider demonstrates knowledge of maternal complications	often**,***
21. Provider demonstrates knowledge of STI symptoms, treatments, and/or referrals	often***
22. Provider demonstrates knowledge of cold chain for immunizations	often***
23. Provider follows infection control procedures (incl. HLD)	always
24. Service providers receive regular, useful supervision	always
25. Clients receive FP methods appropriate for FP needs and STI/HIV prevention	often
Mechanisms to Ensure Continuity	
26. Provider tells client when to return	often****
27. Drop-outs are followed up	often****
28. Reasons for drop-outs are identified	often****
Appropriateness and Acceptability of Services	
29. Clients perceive that there is:	
a. confidentiality for counseling	often
b. privacy for exam	often

* *Providers include FLEP providers and VHWs.*

** *There was one exception among the service providers, a recently hired midwife whose performance was substandard.*

*** *These scores (often instead of always) are due to the fact that complete RHS/immunization integration has not taken place at all sites. Where integration was present, the providers were all knowledgeable in all areas.*

**** *Follow-up of drop-outs varied in clinical sites, especially those sites in which the VHWs lacked transport or funds to seek out the clients to identify reasons for drop-outs.*

EAD QUALITY OF CARE INDICATORS SCORE

Indicator	Score
Interpersonal Relationships	
1. Service providers* are trained in interpersonal relations	inadequate
2. Service providers use IPC skills/GATHER/YOMOMO	often
3. Clients report feeling welcomed and at ease	sometimes
4. Number/range of methods available	always
5. Provider offers all appropriate methods	often
Information Given to Client	
6. Provider demonstrates appropriate counseling skills	sometimes
7. Provider has checklist available on information to cover during counseling session	not seen
8. Provider gives accurate, unbiased overview of all methods	sometimes
9. Provider gives accurate information on accepted methods	sometimes
10. Informational materials are available on all methods	not seen
11. Privacy is acceptable for counseling and exam	not available
12. Consent form is available and signed by client	always
Technical Competence/Training	
13. Written guidelines on FP/STI/HIV/Maternity/ Immunizations are available	not at site
14. Clinical providers receive relevant training for tasks	inadequate
15. Staff members receive periodic refresher/in-service trainings	inadequate
16. Basic items are present for health care delivery	always
17. Provider can accurately explain FP methods, immunization schedules, STI/HIV prevention	sometimes
18. Provider demonstrates skill in clinical RHS procedures (bimanual exam, speculum exam, ysical assessment skills, delivery skills)	always
19. Provider demonstrates knowledge of contraindications to FP methods	sometimes
20. Provider demonstrates knowledge of maternal complications	always
21. Provider demonstrates knowledge of STI symptoms, treatments, and/or referrals	sometimes
22. Provider demonstrates knowledge of cold chain for immunizations	often
23. Provider follows infection control procedures (incl. HLD)	always
24. Service providers receive regular, useful supervision	not done
25. Clients receive FP methods appropriate for FP needs and STI/HIV prevention	sometimes
Mechanisms to Ensure Continuity	
26. Provider tells client when to return	always
27. Drop-outs are followed up	always
28. Reasons for drop-outs are identified	sometimes
Appropriateness and Acceptability of Services	
29. Clients perceive that there is:	
a. confidentiality for counseling	sometimes**
b. privacy for exam	sometimes**

* *Providers include EAD providers, CBDs, and medical students.*

** *Ruharo site provides no privacy; privacy available in other sites visited.*

[1] A catchment area study was planned for the beginning of Phase 3 of the project (late 1992) but was never carried out.

[2] The Prevalence Method of calculating births averted is described in Bertrand et al., 1994:177.